CONFRONTATION

LITERARY MAGAZINE

HUDSON, USA – 2018

ISSUE 123, SPR – II (Special Issue - I), 2018

LONG ISLAND UNIVERSITY

LONG ISLAND UNIV, CW POST COLL, ISSN:0010-5716 UNITED STATES

CONFRONTATION – LITERARY JOURNAL

LIU Hudson

Arts & Humanities Citation Index via WEB OF SCIENCE

Our History

Confrontation Magazine began operation in 1968 with the mission of bringing new talent to light in the shadows cast by well-known authors. Open to all submissions, each issue contains original work by famous and by lesser-known writers.

Among the authors we've published are Nobel prize winners John Steinbeck, Derek Walcott, Isaac Bashevis Singer, Joseph Brodsky, Nadine Gordimer, S.Y. Agnon; and Pulitzer and other prize winners W.H. Auden, Arthur Miller, Ned Rorem, Ed Bullins, Joyce Carol Oates, T.C. Boyle, and Lanford Wilson.

The magazine has also published the work of a 14-year-old talented writer, college students and writers beginning their career. Cynthia Ozick, Paul Theroux, Walter Abish, and Susan Vreeland all published work in the magazine before they achieved wider fame. Confrontation is eclectic; eclecticism is in fact our mission.

Masthead:

Confrontation remains indebted to the generosity of Mrs. Carleton Palmer, without whose legacy no issue of this journal would be possible.

AIMS and SCOPE

Websites: www.confrontationjournal.org
Email: info@confrontationjournal.org
Indexed by Thomson Reuters Emerginch Citation & Scopus & GOOGLE Scholar

720 Northern Boulevard, Brookville, NY 11548
LIU Brooklyn
1 University Plaza (corner of Flatbush and DeKalb Avenues)
Brooklyn, NY 11201
General Phone: 718-488-1000
Admissions Phone: 718-488-1011
Admissions Inquiries: bkln-admissions@liu.edu

CONTENTS

LONG ISLAND UNIV, CW POST COLL, ISSN:0010-5716 UNITED STATES

Article

Influnece of the belieing surgerical pain and the imagination of Human beings

Henry Grimston

Uk, Perkinian Institute, London
Braine_Henry@hotmail.com

Abstract

Treatment of diseases of the brain by drugs or surgery necessitates an understanding of its structure and functions. The philosophical neurosurgeon soon encounters difficulties when localising the abstract concepts of mind and soul within the tangible 1300-gram organ containing 100 billion neurones. Hippocrates had focused attention on the brain as the seat of the mind. The tabula rasa postulated by Aristotle cannot be localised to a particular part of the brain with the confidence that we can localise spoken speech to Broca's area or the movement of limbs to the contralateral motor cortex. Galen's localisation of imagination, reasoning, judgement and memory in the cerebral ventricles collapsed once it was evident that the functional units–neurones–lay in the parenchyma of the brain. Experiences gained from accidental injuries (Phineas Gage) or temporal lobe resection (William Beecher Scoville); studies on how we see and hear and more recent data from functional magnetic resonance studies have made us aware of the extensive network of neurones in the cerebral hemispheres that subserve the functions of the mind. The soul or atman, credited with the ability to enliven the body, was located by ancient anatomists and philosophers in the lungs or heart, in the pineal gland (Descartes), and generally in the brain. When the deeper parts of the brain came within the reach of neurosurgeons, the brainstem proved exceptionally delicate and vulnerable. The concept of brain death after irreversible damage to it has made all of us aware of 'the cocktail of brain soup and spark' in the brainstem so necessary for life. If there be a soul in each of us, surely, it is enshrined here.

Keywords: influence, braine, brainsteam, ancient anatomy

Injury to, and disease in, the brain often provides crucial insights on the role of its different parts. A dramatic example is the injury suffered by American railway foreman, Phineas Gage in 1848. Before his accident, Gage was liked by friends and acquaintances who considered him to be honest, trustworthy, hard working and dependable. A freak accident caused a metal tamping rod to enter under his left zygomatic arch and exit through the top of his skull (Barker, 1995).

The accident left him with little if any intellectual impairment but after the accident, Gage became vulgar, irresponsible, capricious and prone to profanity. The company that had previously regarded him as the most efficient and capable of their employees dismissed him from his job. His change in character after the accident made this the index case for personality change due to frontal lobe damage. Subsequent studies (See, for example, Blumer and Benson, 1975) have shown a wide spectrum of abnormal behaviour (compulsive and explosive actions, lack of inhibition, unwarranted maniacal suspicion and alcohol and drug abuse) after injuries to and disease in the frontal or temporal lobes and their pathways to the deeper regions of the brain.

Similar abnormalities also follow chemical derangements in the brain. Yet as this essay argues, this tradition is itself characteristic of the 'multifaceted ambivalence' of settler-colonial nationalism (Thomas 34). Indeed, conflicts and misconceptions such as those surrounding the Jindyworobaks are typical of settler societies, in which the tensions produced by a system of relations involving settler, metropolitan and indigenous agencies mean that the imperatives towards settler indigenisation and neo-European replication compete for supremacy but are never ultimately resolved (Veracini chapter one). The concluding sections of this paper therefore introduce a settler colonial studies interpretive perspective in order to propose an original interpretation of the Jindyworobaks as neither universalist nor exclusively nationalist, and neither nationalist nor exclusively indigenist, but rather ambivalent settler nationalists expressing the typical settler-colonial desire to overcome the contingencies characteristic of the settler-colonial condition.

There is an important thread in the historiography on Ingamells and the Jindyworobaks that identifies, but cannot specify, the imperatives underlying their approach as deriving from Australia's settler-colonial conditions.[1] Yet this thread does not elaborate the implications of such an interpretation. Importantly, the reinterpretation proposed here is not delimited by either history or geography, yet takes both factors seriously. Indeed, while Les Murray

LONG ISLAND UNIV, CW POST COLL, ISSN:0010-5716 UNITED STATES

has described himself proudly, if half in jest, as the 'Last of the Jindyworobaks' (Elliott, 'Editor's Note' 283), the cultural dynamics of settler colonialism this essay identifies and applies to Ingamells and the Jindyworobaks extend well beyond this admittedly limited historical example. Paul Keating's recent call for the 'blending of black and white Australia to create [a] new national identity' stands as only the most recent and public example of a persistent concern for settler indigenisation (Taylor), or what Philip Mead has described as 'a continuing desire in the white Australian imaginary … for a species of cultural-racial syncretism' (560).Perhaps even more significantly still, the imperatives and exigen- in 1944 on the grounds that she was undertaking A study of Australian literary-historical movements, at one point finding analogous 'moments' in the literary history of another southern continent in the New World: Latin-America. Only its Jindies try to go to a period of the Incas, the Incas whose records and race were blotted out by the Spanish conquest. (Palmer). The act of translating pain into images converts unique, isolated misery into tangiblesuffering, imaginable by other people. Pain that is often tucked away in some private, grey-tinged, shadowy space is abruptly allowed to flow into public consciousness, a well of red anguish. In this public sphere, the struggle that many sufferers face — that of distinguishing bodily from mental distress — is particularly acute. Famously, in the seventeenth century, René Descartes drew a distinction between the mind and the body this dichotomy cies identified here are no more limited by geograph y than they are by chronology: similar movements driven by similar concerns, albeit exhibiting distinctive characteristics on the basis of differing cultural and political contexts, can be identified in, for example, the literary-cultural strands of Andean indigenismo in Latin America (Coronado; Rama), l'École d'Alger (Dunwoodie; Haddour), the Canaanites in Israel (Ohana; Piterberg chapter three), and the Maorilanders in New Zealand (Stafford and Williams). Ever-sensitive and insightful, Nettie Palmer was awake to the comparative dimension at the time the Jindyworobaks were writing, requesting a statement of 'Jindy theory' from Ingamells dominated thinking throughout the nineteenth century. But, as people-in-pain have often discovered, embodiment is not a mechanistic process as Descartes would have it. The inextricable coupling of mind and body is eloquently observed in Virginia Woolf's On Being Ill (1930). 'All day, all night', she writes, the body intervenes; blunts or sharpens, colours or discolours, turns to wax in the warmth of June, hardens to tallow in the murk of February. The creatures within can only gaze through the pane — smudged or rosy; it cannot separate off from the body like the sheath of a knife or the pod of a pea.I

That inner creature who gazes out is a sociable 'self'. Anxiety and terror can encourage the development of communities of sympathy. The person-in-pain seeks succour [Fig. 2]. When overwhelmed with pain as a child, for instance, Harriet Martineau's mother and father would 'tenderly'

call for her to come to them, and she would rest her head on her mother's 'warm bosom […] and [wish] that I need never move again'.2 But visions of physical pain can also arouse cruelty. People-in-pain might be accused of fabricating their own rack upon which to writhe [Fig. 2 and Fig. 4]. Physicians and other care-givers might be impervious to the sufferers' cries [Fig. 3, Fig. 4, and Fig. 5]. 'Imperturbability' is an 'essential bodily virtue' for physicians, Sir William Osler famously declared in 1904, but might it be an ambiguous blessing for patients?3 Anaesthetics and effective analgesics silence the person-in-pain [Fig. 6and Fig. 7]. Pain, once again, retreats to private, silent depths.

The most influential model of pain is the mechanistic one espoused by philosopher René Descartes. In 'Meditations on First Philosophy' (1641), Descartes insisted that 'I have a body which is adversely affected when I feel pain'. He went on to say that

Nature teaches me by these sensations of pain […] that I am not only lodged in my body as a pilot in a vessel, but that I am very closely united to it, and so to speak so intermingled with it that I seem to compose with it one whole.4

Despite Descartes' attempts to show how body and mind 'intermingled', he became known for the Cartesian distinction between body and mind, arising largely from his famous image of the mechanism of pain, which was published in Traité de l'homme, fourteen years after his death.5 In this image [Fig. 1], fast-moving particles of fire rush up a nerve fibre from the foot towards the brain, activating animal spirits which then travel back down the nerves, causing the foot to move away from the flame. According to this model, the body was a mechanism that worked 'just as, pulling on one end of a cord, one simultaneously rings a bell which hangs at the opposite end'.6

It was a profoundly influential theory, especially after it became the model of the body propagated by the founder of clinical teaching, Herman Boerhaave. Despite the fact that it has subsequently been dismantled, Descartes' way of conceiving of pain remained remarkably intact throughout the nineteenth and twentieth centuries. Descartes' filaments and animal spirit were converted into nociceptive impulses and endorphins, but his mechanistic metaphor and the Cartesian distinction between bodily pain and psychological suffering remained in place until Ronald Melzack and Richard Wall invented the Gate Control Theory of Pain in 1965.7 Their model showed how perceptions of pain were modulated by complex feedback systems. Context, including psychological cues, became central to the understanding of pain.

It is often said that the experience of pain isolates sufferers. But pain can also create bonds of sociability. This statue of a man suffering the agonies of gout in his big toe was produced in the late eighteenth century by the distinguished German porcelain company, Meissen [Fig. 2]. Gout typi-

LONG ISLAND UNIV, CW POST COLL, ISSN:0010-5716 UNITED STATES

cally caused agonizing pain in the big toes and other joints. According to the cleric and writer Rev. Sydney Smith, it was 'like walking on my eyeballs'.8 In this figurine the sufferer is surrounded by symbols of the cause of his affliction, that is, alcohol, rich foods, and other evidence of profligate living. Sufferers are responsible for their affliction. His son is shown sitting in a miniature chair with his foot slightly raised, indicating the hereditary nature of the disease. The gout sufferer is receiving succour from his wife. Representations of both the disease and the person providing sympathy are highly gendered. The image of the gout sufferer is almost without exception that of a middle-aged or elderly man, while the person responding with sympathy to the person-in-pain is typically a sexually attractive, young woman.

Thomas Rowlandson sketched 'Amputation' in 1793, over fifty years before the invention of effective anaesthetics such as ether or chloroform [Fig. 3]. It shows a man tied to a chair, having his right leg amputated. He is screaming in agony. The main surgeon is wearing a carpenter's apron and is conducting the amputation with a common saw. An assistant holds a wooden crutch. The amputation is taking place in a dissecting room (a corpse can be seen in the lower right-hand corner) and on the walls are articulated skeletons, alluding to panics about resurrectionists (that is, men who 'resurrected' corpses from graveyards in order to sell them to dissecting schools for use in training medical students). The bewigged and bespectacled doctors are impervious to the man's agony. On the wall is a list of surgeons, including Sir Valiant Venery, Dr Peter Putrid, Launcelot Slashmuscle, Cristopher Cutgutt, and Benjamin Bowels.

. This was particularly the case given 'the horrible fears that anticipation [of amputation] unavoidably excites in the patient's mind' and the 'excruciating pain' of the actual operation.9 As another critic put it in the 1850s, some physicians had acquired a 'taste for screams and groans' and were unable to 'proceed agreeably in their operations without such a musical accompaniment'.10 When effective anaesthetics were eventually introduced, many physicians argued against their use on the grounds that the tortuous pains of surgical operations were necessary to prevent haemorrhage. As the vice-president of the American Medical Association pronounced in 1849, pain was 'curative [...]. The actions of life are maintained by it.' Without 'the stimulation induced by pain', surgery would 'more frequently be followed by dissolution'.11

Eighteenth- and early nineteenth-century medicine was patient-orientated, with sufferers of pain and illness as likely to have recourse to 'quacks' as to regular physicians. Indeed, the distinction between the two kinds of practitioners was not as great as it was to become later in the nineteenth century, with the introduction of state regulation and the professionalization of medicine.

James Gillray's 1801 satire on 'Metallic Tractors' or Samuel Perkins's needles was an attempt to discredit 'quacks' [Fig. 4]. Metallic Tractors were two needles —

one made of brass and the other of iron — with which practitioners would stroke painful afflictions as varied as rheumatism, gout, inflammation in the eyes, erysipelas, epileptic fits, locked jaw, burns, and all kinds of 'pains in the head, teeth, ears, breast, side, back, and limbs'.12 The pain of gout, Benjamin Douglas Perkins (the son of Samuel Perkins and the person who patented the Tractors in the United Kingdom) explained, was caused by a 'want of perspiration' in the toe which made it become 'positively electrified' while the 'other perspiring parts of the body [were] negatively electrified'. The pain would disappear if the 'equilibrium of electricity' could be restored 'by means of the distribution of the negative electricity in the body to the positive'. A healthy physician who was 'negatively electrified' should hold the Metallic Tractor against the painful toe, effectively communicating his negative electricity to the inflamed toe.13 Tractors were sold in the UK for five guineas, or the annual salary of a female servant.

Gillroy's sketch pits an arrogant, charlatan physician against a 'True Briton' who has been over-indulging in alcohol. On the wall hangs a painting of Dionysus, riding on a West Indian rum barrel, and, on the table, punch made of brandy, tea, sugar, and lemons is brewing. The patient is experiencing extreme pain: his hands are clenched, his teeth are grinding, and his wig is falling from his scalp. His dog howls in sympathy.

'Metallic Tractors' were exposed as a fraud by Dr John Haygarth in Of the Imagination, as a Cause and as a Cure of Disorders of the Body (1800).14 Defenders of the Perkinean Institute, however, claimed to be able to prove the efficacy of the needle. One defender of metallic tractors claimed to have cured a labouring man from Etton (Yorkshire) of 'violent Rheumatism in his right arm'. Afterwards, when the patient was asked his opinion of the operation, he replied that he thought it was 'very silly'. This response convinced the defender of the tractors that the cure had not been due to 'the imagination, but the Metallic Tractors'.15

Emile-Edouard Mouchy's oil painting of 1832 shows a 'physiological demonstration' of a dog inside a garret [Fig. 5]. The dog is tied to the table, which has been specially fitted with metal rings. The dog is clearly howling in pain but the overall arrangement of the painting is of scientific objectivity and manly rationality. Indeed, the painting was intended to valorize physiological experiments as central to scientific progress. There has been some speculation that the surgeon is François Magendie, the foremost French experimental physiologist who, in the 1830s, would start his lecture series by opening the abdomen of a dog.

Do dogs like the ones in this painting truly feel pain? For vivisectors, the answer was simple: animals were close enough to humans to make such experiments worthwhile but not so close to make vivisecting them cruel. According to Descartes, animals

LONG ISLAND UNIV, CW POST COLL, ISSN:0010-5716 UNITED STATES

were mere 'automa' or moving machines, driven by instinct alone. He believed that animals' screams of pain were simply mechanical responses, which functioned as a form of human moral edification.16 More commonly, scientists and philosophers of the early nineteenth century pointed to the existence of a hierarchy of sentience. After all, they insisted, isn't it the case that not all humans are equally sensitive? The ability to feel, both in terms of physical sensation as well as inner sensibilities, was ranked hierarchically. The regulation of vivisection — because it involved cruelty towards animals, but also on the grounds that allowing cruelty to animals would open the door to cruelty towards people — occurred earlier in the UK than in the rest of Europe. Indeed, British physiologists such as Sir Charles Bell were much more likely to emphasize dissection as opposed to the French tradition of vivisection.

This is the first daguerreotype of a real operation [Fig. 6]. It was created on 3 April 1847 in the amphitheatre of the Massachusetts General Hospital, where ether had been first used publically as an anaesthetic, six months earlier. It was taken by the famous daguerreotype studio of Albert Southworth and Josiah Hawes, in part as a way of memorializing the pain-shattering achievements of the hospital. The patient — whose head is turned towards anaesthetist Dr Charles Heywood, who holds an ether-soaked sponge — is Athalana Golderman, a young seamstress, who had unintentionally stabbed herself in the leg with her scissors. At the foot of the operating table, on the right-hand side, is John Collins Warren, the surgeon who had performed the first public operation employing William Morton's ether. Opposite him is his son, Jonathan Mason Warren, who had introduced the use of the sponge to administer ether. To the left and rear of the photograph there is a human skeleton and on the right the base and lower limbs of the Apollo Belvedere, a statue of the Greek god associated with healing. The operation is being watched by students and visiting physicians who sit in a semicircle of benches that rise up steeply along the sides of the amphitheatre.

The introduction of anaesthetics was widely regarded to have promoted a certain kind of detachment, and certainly the staged feel of this daguerreotype effectively catches this new, surgical comportment. The impact of anaesthetics on operatives was alluded to by James Miller in Surgical Experience of Chloroform (1848) when he noted that, in the days before anaesthetics, medical students and surgeons 'grew pale and sickened, and even fell, in witnessing operations' — not because of the 'mere sight of blood, or of wound' but 'from the manifestation of pain and agony emitted by the patient'. In contrast, he continued, after the invention of anaesthetics these medical practitioners were spared the need to emotionally engage (or, indeed, attempt to disengage) with patients since 'a snort is the worst sound' they made.17 In the words of a physician writing in 1863, surgery became 'slow dissection', a term generally used about corpses, not living patients.18 David Cheever bluntly expressed it in 'What has Anæsthetics Done for Surgery?' (1897): as

a result of anaesthetics, he observed, the surgeon 'need not hurry; he need not sympathize; he need not worry; he can calmly dissect, as on a dead body'.19

This watercolour by Richard Tennant Cooper was commissioned in 1912 by Henry S. Wellcome, the founder of the influential charity, the Wellcome Trust [Fig. 7]. It suggests some of the more disturbing aspects of chloroform. While the body is rendered insensible, it is toyed with by demons and bat-like spirits. Anaesthetics transport the patient into a state without physical pain, but they also unleash worlds of unconscious, hostile drives. They render the person passive. The painting also portrays anxieties about the comatose body, placed at the mercy of outside agents, including surgeons. This was one reason for the hostility to anaesthetics when they were first introduced. Critics observed the immense power that anaesthetics gave surgeons over patients: patients could be treated as 'things', with no rights over their own body. In the words of physician James Arnold in The Question Considered; Is It Justifiable to Administer Chloroform in Surgical Operations (1854), the 'apoplectic stupor produced by chloroform' placed the patient at 'risk of delirious expression of thought' — that is, they might utter impious oaths rather than invoke verses proclaiming their closeness to the suffering Christ. Arnold regarded this as a problem, 'as respects woman particularly'. If women were made aware of this risk in using chloroform, it would 'deter them from its unnecessary use' (Arnold, pp. 16, 24). Chloroform disrupted coherent, godly pain-narratives. The insensible body was vulnerable to all manner of abuses.

References

1. Aristotle On the soul. 2009. Available at: http://classics.mit.edu//Aristotle/soul.html [Accessed on 14 Sep 2009]
2. Arnold E. The Song Celestial or Bhagavad-Gita (From the Mahabharata) Being a Discourse Between Arjuna, Prince of India, and the Supreme Being Under the Form of Krishna. New York: Truslove, Hanson and Comba; 1900.
3. Baff M. X Ray Moving Picture Machine Shows Brain At Work; Dr. Max Baff of Clark University Tells of the Remarkable Invention of a Scientist at Buenos Ayres Which May Pry Into the Soul's Secrets. The New York Times Magazine. 1910. September 4, 1910, Sunday. Section: Magazine Section, Page SM4. Available at http://query.nytimes.com/mem/archive-free/pdf?res=9F0DE3D61E39E333A25757C0A96F9C946196D6CF [Accessed on 17 Dec 2010]

4. Barker F.G., 2nd Phineas among the phrenologists: the American crowbar case and nineteenth-century theories of cerebral localization. J Neurosurg. 1995;82(4):p672–682. [PubMed]
5. Bloom P. The Duel Between Body and Soul, The New York Times, 10 September. 2004
6. Blumer D, Benson D. Personality changes with frontal and temporal lobe lesions. In: Benson D, Blumer D, editors. Psychiatric Aspects of Neurologic Disease. New York: Grune and Stratton; 1975.
7. Breathnach C. Charles Scott Sherrington's Integrative Action: a centenary notice. Journal of the Royal Society of Medicine. 2004;97:p34–36. [PMC free article] [PubMed]
8. Browne T. (1636/2009) Religio medici. 1635. Available at: http://www.fordham.edu/halsall/mod/1643Browne-religio.html [Accessed on 7 Dec 2010]
9. Carey B. H. M., an unforgettable amnesiac, dies at 82. The New York Times. 2008 4 December.
10. Carter R. Mapping the mind. Berkeley: University of California Press; 1998.
11. Dean C. Science of the Soul? 'I think, therefore I am' is losing force. The New York Times. 2007 26 June.
12. Del Maestro Rolando F. Leonardo da Vinci: the search for the soul. The Journal of Neurosurgery. 1998;89:p874–887. [PubMed]
13. Ahluwalia, Pal. 'When Does a Settler Become a Native? Citizenship and Identity in a Settler Society.' Pretexts: Literary and Cultural Studies 10.1 (2001): 63-73.
14. Ashcroft, Bill, Gareth Griffiths and Helen Tiffin. The Empire Writes Back: Theory and Practice in Post-Colonial Literatures. 1989. 2nd ed. London: Routledge, 2002.
15. Bird, David S. Nazi Dreamtime: Australian Enthusiasts for Hitler's Germany. North Melbourne: Australian Scholarly Publishing, 2012.
16. René Descartes, 'Meditations on First Philosophy', in *Descartes: Key Philosophical Writings*, trans. by Elizabeth S. Haldane and G. R. T. Ross, ed. by Enrique Chávez-Arvizo (Ware: Wordsworth Editions, 1997), pp. 123–90, (p. 183).
17. René Descartes, *Traité de l'homme* (Paris: Clerselier, 1664), p. 27.

Article

A recording mechanism for memories of events

Benjamin Cunningham, Langworthy

Penguin Uni., Pathaology and Physiology Department

Benj9878@hotmail.com

Abstract

'It is obvious that there is, beneath the electrode, a recording mechanism for memories of events. But the mechanism seems to have recorded much more than the simple event. When activated, it may reproduce the emotions which attended the original experience. What is more, the ganglionic mechanism continues to add to itself the memory of emotions which attend the recollection of the event and the substance of the man's reasoning regarding the significance of the event…'The neuronal mechanism which we have stumbled upon in the course of neurosurgical operations, and which is probably duplicated in homologous areas of the two hemispheres, seems to have for its function the reproduction of (1) a remembered event or (2) thinking related to that event, and (3) the emotion it evoked' (Horowitz, 1997).

Keywords: mechanism, memories, eventual.

On 1 September 1953, Dr. William Beecher Scoville performed bilateral mesial temporal lobe resections on a patient known as H.M. in the medical records. The inadvertent severe damage to the important limbic structures resulted in permanent loss of memory in this patient (Scoville, 1957). H. M. knew his name. He knew that his father's family came from Thibodaux, LA, and his mother was from Ireland, and he knew about the 1929 stock market crash and World War II and life in the 1940s. But, he could remember almost nothing after that. Dr. Brenda Milner, professor of cognitive neuroscience at the Montreal Neurological Institute and McGill University studied H. M. almost up to his death in 2008 and noted: 'He was a very gracious man, very patient, always willing to try these tasks I would give him and yet every time I walked in the room, it was like we'd never met' (Carey, 2008). The indigenist aspect of the Jindyworobak program and the imperative behind it also complicates

LONG ISLAND UNIV, CW POST COLL, ISSN:0010-5716 UNITED STATES

the various attempts to classify them as either anti-modernist provincial isolationists or, conversely, modernist primitivists. The traditions remain distinct, since the imperatives underlying the settler-colonial compulsion towards indigenism are not commensurate or reducible to those underlying the metropolitan modernist turn towards primitivism. Whereas the latter seeks to recuperate an already superseded and generic state of being as a means of overcoming or escaping a modern malaise conceived in universal (read European) terms, the former seeks to appropriate aspects of a particular and emplaced alterity for the purposes of attaining an always and already desired futurity within a specific locale, the very conditions of which compel their supersession. As Nicholas Thomas remarks:

Primitivism in settler culture is … something both more and less than primitivism in modernist art … Settler primitivism is not … necessarily the project of radical formal innovation stimulated by tribal art that we are familiar with from twentieth-century modernism. It was, rather, often an effort to affirm a local relationship, not with a generic primitive culture, but a particular one. Reflections on the feelings aroused by the sight and by the idea of the surgically opened, living body command the attention of the historian of emotions. The article explores the ways in which the *sight* of suffering — the aesthetics of pain — were mitigated, justified, rationalized, and subjected to emotional control. It argues that a diminution of the aesthetic response to the sight of blood, in conjunction with knowledge of anaesthesia, allowed physiologists to conform to a moral code that abstracted compassion to suffering on a wide scale, removed from the immediacy of the laboratory, and in the name of 'humanity'. This in turn was connected to a newly developed notion of compassion or sympathy at the level of the whole community, of the whole species, or even of all sentient life, that had emerged from the moral philosophy of the theory of evolution. In this context, physiologists' reflections on their emotional equanimity in the laboratory can be connected to the operating callousness of the physician, and both are located in a secular, Darwinian context of the evolution of the emotions. This stands in contrast with antivivisectionist charges of callousness and their own aesthetics of compassion — their own emotional pain — that endured the rise of anaesthetics in physiological experiments.1

Historians have found late nineteenth-century physiologists' equanimity difficult to imagine in practice. Patrizia Guarnieri has opined that 'the activity of the vivisectionist did not necessarily preclude a caring attitude towards animals, or a reciprocal relationship of good-will', but the two things were nevertheless incompatible:

On the one hand, the white-collared scientist who tied down an etherised dog on the operating table who […] opened its skull and removed the cranial lobes. On the other, the gentleman who always had some delicacy in his pockets for the animals, and made sure that they lacked neither food nor affection. A sort of Dr Jekyll and Mr Hyde perhaps.2

She is not the only one to have drawn such a conclusion. Stewart Richards cri-

tiqued the physiologists of the 1870s and 1880s thus:

Whatever their ethical imperatives as private citizens (when they were evidently no less humane than other men), they were able as professional scientists, temporarily but repeatedly, to suspend 'normal' sensibilities in a way that we may recognize as more widely familiar throughout history than the singular case of Dr Jekyll and Mr. Hyde.

He went on to wonder whether John Burdon-Sanderson, about whom more below, had fallen, 'like Dr. Moreau [...] under the spell of research', which was the 'source of a psychological commitment to specific instrumental norms that overwhelmed or obscured any more broadly based ethical misgivings'.3 Paul White has similarly pointed to a process whereby practitioners underwent a 'reversion' in the laboratory, wherein 'bestial instincts were unleashed through the repeated and prolonged infliction of pain on helpless creatures'. This destabilized the 'boundaries between the animal and the human' in the name of clarifying them. Physiologists represented a 'divided self', 'struggling [...] to overcome instinctual sympathies for other creatures in order to fulfill commitments to a higher good'.4

With regard to the latter struggle, White is correct, but I want to develop that argument in terms of the history of sympathy itself. Indeed, I want to explore an idea that White himself has suggested with regard to vivisection, but which is as yet undeveloped: the 'crux of the late-Victorian debates was not just whether particular feelings were present in the experimenter or the animal, but the nature of emotion itself; its role in science and medicine — and in human society generally — seemed open to question'.5 Testing the historiographical credence given to the hardened heart of the late-Victorian scientist requires an investigation into what physiologists thought about causing (or avoiding causing) pain in animals.6 It is necessary to ask what changed after the use of anaesthetics became widespread — whether it matters that the vivisected dog in Guarnieri's imagined scene was 'etherised'. If one chooses not to set out to find Edward Hyde or Dr Moreau, one may encounter instead a complex individual who managed a logical consistency in his ethics and practice, and who did not exemplify a Victorian caricature of personality disorder. If we wish to leave literary fantasies behind, we need to inquire anew about the ways in which pain in the laboratory was conceptualized, reflexively experienced, and ethically handled.7

The controversy over vivisection that began with the publication of the *Handbook for the Physiological Laboratory* in 1873, in the context of a prolific development of physiological specialism imported from Continental Europe, has a well-established historical narrative.8Public attention was focussed by a Royal Commission on the Practice of Subjecting Live Animals to Experiments for Scientific Purposes, followed by the Cruelty to Animals

Act of 1876, by which animal experimentation became subject to a government licensing system. The public inquiry of the mid-1870s encompassed the following questions: the utility of experimental research; the 'humanity' of physiologists at home and abroad; and the degree to which animals could, or should, suffer pain. In general within medical science, there was little dissension with regard to the benefits already derived, and the wealth of humanitarian relief to follow, from physiological research. The difficulty lay in the moral price at which those benefits were purchased. The Royal Commission proceeded to assess this difficulty, paying considerable attention to the moral consequences of animal pain and the use of anaesthetics. I will deal with these two things in turn.

To what extent were experimental animals thought to feel pain? Where did that pain weigh in the balance of comparative suffering? The answers to these questions allowed medical scientists to rationalize their own feelings in response to the experience of (inflicting) animal pain. G. M. Humphrey, Professor of Anatomy at the University of Cambridge, told the Royal Commission that the comparative smallness of animal nervous systems indicated that they could not possibly suffer so acutely as humans. Moreover, signs of a struggle were not construed as reliable indicators of pain. The 'violent contortions of the worm' on a hook did not necessarily indicate pain, 'for there may be violent contortions and no suffering whatever'. So much, Humphrey said, had been learnt from the painless muscular excitations of men under chloroform, which looked like pain but were not, as well as from the painless convulsions of epileptics.9

This commonly stated opinion captured physiologists' distrust of the outward signs of pain, which might otherwise have led to unwanted or inappropriate emotional responses to it.10 Such reactions were deemed part of a culture of sentimentalism against which physiology aligned itself. It was exemplified by the secretary of the Royal Society for the Prevention of Cruelty to Animals, John Colam, who told the Royal Commission of his attendance at a lecture in the Spring of 1875 at the London Institution, given by Sir David Ferrier. It was probably a version of Ferrier's Croonian Lecture, given in May of that year, on 'Experiments on the Brain of Monkeys'.11 Ferrier described in great detail his methods of removing parts of the brains of various monkeys, and his observations of their altered states thereafter. The audience, which was comprised of the general public, including 'several young people' and 'several young ladies too', laughed throughout at Ferrier's descriptions of the monkeys' grotesque movements and facial contortions. Colam thought the lecture 'was a long way out of good taste', and was 'sensational'. He was not alluding to the aesthetic qualities of monkeys, who were 'incapable of suffering' during the operations, but rather to it being 'a case of levity, likely to produce a bad effect'. These important investigations were objectionable because they were pitched at the level of 'what is called popular'. There was, Colam thought, 'scarcely that decorum which you would

expect [...] in a man who was describing the condition of animals which had been mutilated by himself'. The grotesque nature of the subject, coupled with the audience's response to it, caused Colam and his companions pain. Indeed, one of his accompanying gentlemen 'left the room in consequence of the pain with which he saw the laughter of the young people' (Royal Commission on Vivisection, pp. 82–83).

Physiologists believed that the lack of pain in the animal removed any objections on the grounds of taste, and saw the emotional pain of antivivisectionists under such conditions as nothing more than a sentimental (feminine) reaction. James Crichton-Browne, the eminent alienist, had defended Ferrier, with whom he worked at the West Riding Asylum, in precisely these terms. The outward signs of pain could be achieved in animals without a brain, 'or in the deepest state of anaesthesia' by a simple 'stimulation of the motor centre'. The apparent 'intense and protracted agony' was 'not greater than that of a pianoforte when its keys are struck'.12

According to George Burrows, who was President of the Royal College of Physicians, only a 'very limited number of experiments [...] will cause a degree of pain to the animal', and under those circumstances it would be 'painful to the operator and to everybody else to contemplate'.13 Compassion in the immediate setting of the laboratory was therefore rationally limited. The pathologist James Paget, trusting in the 'general humanity of scientific men', thought they could be 'left to be fair judges' of the 'amount of pain it is reasonable to inflict for the sake of attaining some useful knowledge'.14 The common concern that vivisection tended to brutalize the operator could be dismissed on the basis that animals' exposure to pain was minimized, for some of them by their lowly nervous systems, and for others by the use of anaesthetics. The anatomist William Sharpey was convinced that experimentation did not have 'the effect of blunting the feelings' or 'hardening the nature' of physiologists, but most agreed that this had to do with the superior qualities of the men involved.15 As Darwin's principal disciple George Romanes, who was himself a practising physiologist, later pointed out, 'our physiologists as a class are not less English gentlemen because they are highly cultured men of science'.16

Even after the use of anaesthetics was prevalent, comparative capacities of sensitivity to pain were continually used to justify experimentation, perhaps because anaesthesia was not deemed appropriate for every experiment.17 'The sole means', according to the psychologist Edmund Gurney, of arriving at a 'conscientious estimate of others' suffering [...] lie in imagining it as one's own'. The anthropomorphism of this cross-species compassion raised the suspicion that animals were commonly allocated a greater capacity for experiencing pain than their physiologies warranted. Gurney argued for a 'close relation of suffering to intelligence'.18 Intellect was the key factor

that enhanced suffering, and humans — even to the ardent utilitarian — were thought to have the largest share. Some animals shared the physiological systems of humans, but their brains were 'in proportion to the rest of the body, very much smaller than in the case of man' (Collier, p. 624). Given the likely benefits derived from physiology, vivisection could thus be justified.

These utilitarians had a good precedent for proceeding in this manner, for J. S. Mill had long since said that a 'being of higher faculties requires more to make him happy, is capable probably of more acute suffering, and certainly accessible to it at more points, than one of an inferior type'. It was, after all, worse to be a human being in pain than a pig in pain; worse to be Socrates in pain than a fool in pain.19 The twist was to say, with one eye on the anti-vivisection movement, that if anybody thought differently about the pig or the fool on behalf of the pig or the fool, they were guilty of a category error, for in fact these advocates only knew their own side of the equation.

At the International Medical Congress (IMC) held in London in 1881, John Simon gave a widely heralded speech defending medical science. He particularly denounced the aesthetic sensibilities of anti-vivisectionists: 'In certain circles of society', he said, 'aesthetics count for all in all; and an emotion against what they are pleased to call "vivisection" answers their purpose of the moment as well as any other little emotion.' The medical profession could not seriously argue with such people, for they did not share a moral standard, or a world view:

We have to think of usefulness to man. And to us, according to our standard of right and wrong, perhaps those lackadaisical aesthetics may seem but a feeble form of sensuality.

But that was not to say that he felt nothing with regard to his work. On the contrary, he thought of inflicting pain 'with true compunction', but he did it nonetheless because of the 'end which it subserves': the promotion of 'the cure or prevention of disease in the race to which the animal belongs, or in the animal kingdom generally, or (above all) in the race of man'. Under such conditions he would not 'flinch' from this 'professional duty, though a painful one'. Simon was referring to his own pain.20

British medical scientists in the 1870s and 1880s were therefore acutely aware of the reflexive problems of causing pain. At worst, it might adversely affect their own 'nerve', and prevent them from following through their inquiries to the fullest extent. The infliction of pain on an animal, where unnecessary, might betray a callousness that could affect society at large. Physiologists generally concluded that vivisection without anaesthetic was difficult because animal suffering was, however mitigated, real. But, all things considered, it was worth it, nonetheless.

III

Physiologists thought that concerns about causing pain should have been put to rest by the widespread use of anaesthetics, which were employed in the vast majority

of experiments. The primary benefit of anaesthetics was not that the experimental animal no longer suffered, but that the major concerns of the physiologist were alleviated: the greater good could be sought unhindered, the operator would not lose his nerve, and he would safeguard his 'feeling' heart. On a practical level, it also meant that the animal would keep still, though this fact was seldom mentioned.21 Anaesthesia objectified the experimental subject, allowing physiologists methodically to remove emotions, not *from* themselves, but *to* more distant, abstract objects. Without anaesthetic, the experimental animal's status as a sensitive being could involve it in a reciprocity of aesthesia, of physical pain in the animal and the reflection of that pain — compassion — in the operator. This might inhibit the researcher in beginning, or in pursuing the ultimate ends of his research. As Carolyn Burdett has recently argued:

Aesthetic response belongs in the relation between viewer and object, as a consequence of what the object precipitates or excites in the body of the viewer. What the viewer then experiences (the consequent feelings or emotions), they then project back and experience anew, as if located in the object.22

Indeed, not to feel this sympathetic pain might be a sign of brutality, giving rise to the 'general accusation of hardness' to which medical science was accustomed.23 Chloroform and ether were safe ways to cut this reciprocal aesthesia, replacing it with a similar but opposite reciprocity of *an*aesthesia that could preserve both the nerve and the tenderness of the operator.24 The benumbed object excited nothing in the viewer (operator), eliminating the possibility of projecting sensation back into the object. As such, William Carpenter averred that 'removing' pain had become a 'matter of duty' for physiologists, who could project their sympathetic gaze outside of the laboratory (Royal Commission on Vivisection, p. 282). By rendering the experimental subject as object, emotions were removed from the physiological procedure, in the name of a more abstract 'humanity'.25

There is a wealth of evidence to demonstrate that physiologists knew that they were doing exactly this, even though they may have thought it possible without anaesthetics.26 John Burdon-Sanderson, co-author and editor of the *Handbook for the Physiological Laboratory*(1873), averred his belief in a certain capacity inherent in the highly evolved civilized male. A man, much more so than a woman, was capable of 'directing mental effort to a recognized purpose' without succumbing to the 'greatest enemies', those 'emotional or sentimental states', including sympathy, which so often 'handicapped' women in their endeavours. A scientific man was singularly well equipped for a 'life directed to the fulfilment of a recognized purpose to which others must yield'.27 Burdon-Sanderson famously neglected the subject of anaesthetics in the *Handbook*, and was

repeatedly asked to justify the infliction of pain in the physiological laboratory, which he did by reference to 'the circumstance that we are working for an important and good object' (Royal Commission on Vivisection, p. 142). But if the infliction of pain could be justified if there was 'a certainty that the human race would be benefited by it', how much more easily could an experiment be justified under anaesthesia? (Royal Commission on Vivisection, p. 146.) Burdon-Sanderson acknowledged that he 'should condemn the non-employment of anaesthesia' wherever anaesthesia could be used, and indeed acknowledged that he had failed in not making this clear in the *Handbook* (Royal Commission on Vivisection, pp. 115, 119, 126.) Yet he remained convinced that responsibility for ensuring the 'greatest possible result', 'at the expense of as little suffering as possible', lay with the scientist himself (Lady Burdon Sanderson, pp. 101, 103). It might even be argued that the failure of the *Handbook*'s authors to make humanitarian overtures towards those whom Burdon-Sanderson would have adjudged to have succumbed to their 'emotional or sentimental states' was consistent with an imperturbable direction of mental effort. The *Handbook*'s diagrammatical gaze into the bodies of the frog, the rabbit, and the dog was imagined in such a way as to avoid the aesthetic sensibilities associated with the bloody wound. Rather, furry-edged incisions were simply windows, abstracted from the animal body as a whole, displaying veins, arteries, nerves, ganglions, and glands [*Fig. 1*].28

Another of the *Handbook*'s authors,the noted Scottish physician Thomas Lauder Brunton, also expatiated on the special qualities of the scientist, making the distinction between two types of compassion. Both medical scientists and antivivisectionists were 'anxious to lessen the amount of pain and suffering in the world', but where one looked to 'the immediate and designed suffering of a few score of animals', the other looked to 'the ultimate relief of the undesigned pains of disease in animals and in men'. To civilized people, Lauder Brunton admitted, the 'mere sight of suffering is painful'. This 'painful impression' causes some immediately to turn away and thus 'be rid of the disagreeable feeling'. For others, 'it excites a desire to relieve the pain of the sufferer, however disagreeable, disgusting, or trying the task may be.' He put physiologists in the latter group. Such a 'power of controlling one's own emotions, of disregarding one's own feelings at the sight of suffering' varied from person to person, but it could be trained. It involved subordinating emotion to judgement, and it was aided in the case of physiology by practice, knowledge, and anaesthetics. The daily experience of experiment would, in itself, help with the process of putting judgement before feeling, allowing these 'humane men' to 'purchase future good at the expense of present pain'.29 E. Ray Lankester had made the same point in 1873, pleading that the 'experimenter often suffers most acutely from his sympathy with the animal, but controls his emotion and endures his pain in companionship with the dumb animal for the sake of sci-

ence'.30 But since the 'great majority' of experiments were 'rendered painless by means of anaesthetic agents', physiologists could, with measured judgement, learn 'to disregard their own feelings, and to concentrate their attention on the interests of the [human] patient' (Lauder Brunton, p. 480).

It was to this measured judgement that the physician and great supporter of vivisection, William Osler, referred in 1889, before a class of new graduates in medicine at the University of Pennsylvania. Osler, whose experience defending vivisection was transatlantic in scope, saw the essential connection between vivisection and surgery, and felt that the qualities of the 'imperturbable' surgeon were kindred with the laboratory physiologist.31 The practitioner was lost if he felt his patient's pain.32 He urged his new young colleagues to have their 'nerves well in hand' and to avoid the slightest facial expression of 'anxiety or fear' even under 'the most serious circumstances'. To fail in this regard betrayed an inability to put one's 'medullary centres under the highest control', and would lead to disaster. 'Imperturbability' was a 'bodily endowment' that ensured 'coolness', 'calmness', and 'clearness of judgment in moments of grave peril'. It was character defined by '*phlegm*':

Now a certain measure of insensibility is not only an advantage, but a positive necessity in the exercise of a calm judgment, and in carrying out delicate operations. Keen sensibility is doubtless a virtue of high order, when it does not interfere with steadiness of hand or coolness of nerve; but for the practitioner in his working-day world, a callousness which thinks only of the good to be effected, and goes ahead regardless of smaller considerations, is the preferable quality.

He urged his young charges to 'cultivate [...] such a judicious measure of obtuseness' that would 'meet the exigencies of practice with firmness and courage, without, at the same time, hardening "the human heart by which we live"'.33

For Osler, physiologists had the additional quality of an 'experimental spirit in medicine', with which there was 'nothing else in human endeavour to compare from the standpoint of humanity'. He agreed with his colleague Harvey Cushing that there was a 'feeling of regret [...] that animals, particularly dogs, should thus be subjected to operations, even though the object be a most desirable one and accomplished without the infliction of pain', but his conclusion was clear: the 'humanity of the physiologists' could be trusted implicitly. This humanity — compassion in the broadest sense — had been adhered to through 'lives of devotion and self-sacrifice', through a useful callousness, and carried to an 'incalculable' extent.34

Osler affirmed this in 1907, but it had been forcefully asserted by the institution of medicine at large as early as 1881. The IMC in London, the largest ever assemblage of eminent medical men from around the world to that date, unanimously passed a resolution that had been drawn up under

the auspices of the Physiological Society. It recorded the latter's 'conviction that experiments on living animals have proved of the utmost service to medicine in the past, and are indispensible to its future progress'. It strongly deprecated the infliction of 'unnecessary pain', but demanded 'in the interest of man and of animals' that 'competent persons' should not be restricted in their experiments.35 In addition, many of the age's most prominent medical scientists and physicians came forth with their own similar defences. Gerald Yeo, professor of physiology at King's College London, underscored the profession's abhorrence at the infliction of pain by laying before the public an extended analysis of the prevalence of anaesthetic usage, setting out to prove that there was no 'want of tenderness amongst English physiologists' and that 'Pain forms […] but a rare incident in the work of a practical physiologist'. William Gull emphasized the 'moral duty' of investigating 'problems of the highest importance to mankind' when the 'solution of these problems is within the scope of the human intellect'. This course by no means made physiologists 'indifferent to or careless of inflicting pain'. Their character had already been safeguarded by the 1871 resolutions of the British Association, the first of which read: 'No experiment which can be performed under the influence of an anaesthetic ought to be done without it.' It was with happiness that he noted that the 'great majority' of experiments on the nervous system 'are performed on decapitated frogs, or on other animals under the influence of anaesthetics'.36

Physiologists, as a body, were pain-aware, mindful of the freedom given to them by anaesthetics and focussed on what they perceived to be the higher moral ends of their operations. Those moral ends, understood as the alleviation of all human suffering, were embedded within the moral theories of Darwin and his contemporaries, who sought to explain the evolution of compassion as the mainspring of moral action. To better appreciate those moral ends, as well as to understand the grounds upon which antivivisection could be rejected, we must turn to the evolutionary ethics that informed physiological practice.

The link between physiology and evolutionary ethics is abundantly clear, and Darwin himself worked behind the scenes in collaboration with John Burdon-Sanderson, John Simon, T. H. Huxley, and others to ensure protective legislation for physiologists.37 George Romanes, one of Darwin's most ardent supporters, was a principal agitator in the defence of physiology, and even suggested that Darwin write a pro-vivisection article for the monthly literary journal, the *Nineteenth Century*, entitled 'Mistaken Humanity of the Agitation: Real Humanity of Vivisection'. Thomas Huxley served as the most notable defender of vivisection on the committee of the Royal Commission on Vivisection, while elsewhere publicly denouncing 'the venomous sentim[ent]ality & inhuman tenderness of the members of the Society for the infliction of cruelty on Man — who are ready to let disease torture hecatombs of men as long as poodles are happy'. Herbert Spencer is reputed to have regarded vivisec-

tion to have been 'so justified by utility to be legitimate, expedient, and right', on the condition of State supervision.38 In their defence of physiology, evolutionary ethicists offered a new interpretation of the meaning and implications of sympathy and compassion.

Robert J. Richards has clearly demonstrated that Darwin's evolutionary ethics was 'a morality of intentions'. This meant judging moral action not on what was done, in abstraction, but on the intended outcome. To better do this, according to Darwin, 'we must look *far forward* & to the *general action* — certainly because it is the result of what has *generally* been best for our good *far back*.'39 The loose body of evolutionary scientists characterized antivivisectionists as adherents to a 'false' or 'mistaken' humanity because they allowed their conduct to be led by an immediate reaction to what they saw, or sensed, as wrong, without due consideration for what was actually good for humanity. Sympathy in an advanced civilization was extended beyond the confines of the family through its connection to the evolution of the intellect. 'The highest possible stage in moral culture', Darwin wrote, 'is when we recognise that we ought to control our thoughts'. Sympathy, by a process of reason, could therefore be extended to all, including animals.40 But that also meant that an immediate sympathetic reaction could be suppressed for the sake of a greater good. The application of Darwin's own moral theory to the matter of vivisection is startlingly clear. In his most famous contribution on the subject Darwin wrote of the

> incalculable benefits which will hereafter be derived from physiology, not only by man, but by the lower animals [...]. In the future every one will be astonished at the ingratitude shown, at least in England, to these benefactors of mankind.41

For Darwin, anaesthetics were morally desirable, but once used there could be no remaining objection to vivisection, a term he wished to replace with 'anaes-section' to clear up any moral doubts (*Life and Letters of Charles Darwin*, III, 202). Even without anaesthetics, an operation could be justified 'by an increase in our knowledge', and could give the operator protection against the 'remorse' that would otherwise arise from his procedures (*Descent of Man*, p. 90). The evolution of sympathy allowed the 'surgeon to harden himself whilst performing an operation, for he knows that he is acting for the good of his patient' (*Descent of Man*, p. 159).

Darwin's work on the moral sense was complemented by Herbert Spencer's *Principles of Psychology* (1855).42 Put succinctly, the more evolved the emotional being, the more considered, and the less impulsive, would be the conduct of that being. It would be better equipped to see the long-term consequences of its actions, and to decide on the best overall moral action. 'An emotional nature not well developed', Spencer said, 'will be relatively impulsive — the liability will be for each passion to display itself quickly and strong-

ly, without check from the rest.' With a higher development of the emotions, 'there will be little liability to sudden outbursts of feeling.' The resulting conduct, derived from a more complex and 'a greater number of feelings severally less excited', was likely to be 'more persistent'. Spencer was outlining the contrast between civilized and 'savage', but, as was typical, he averred that an illustration of his theory was 'furnished by the contrast between men and women' (*Principles of Psychology*, I, 583). The overwhelming characterization of antivivisection as a women's cause allowed antivivisectionist arguments to be dismissed in these Spencerian terms.43 The demand for the abolition, or severe curtailment, of vivisection arose from impulsive responses to emotional stimuli. At the apogee of evolution, the white, male physiologists, who were all well versed in Darwinian morals, could claim their greater equanimity.44 All things considered, what they were doing was for the greater good. They could bury their immediate sympathies and carry on.45

Compassion for Spencer was styled the 'tender emotion' or 'pity'. Simply put,

pity implies [...] the representation of pain, sensational or emotional, experienced by another; and its function as so constituted, appears to be merely that of preventing the infliction of pain, or prompting efforts to assuage pain when it has been inflicted.

This description adequately describes both the objection of antivivisectionists when anaesthetic was not thought to be in use, and physiologists' doubts when anaesthetics were not available, reliable, or preferable for certain experiments. But how did the evolutionists explain the continued presence and persistence of pity even where there was no pain? Spencer drew attention to a 'certain phase of pity' in which 'the pain has a pleasurable accompaniment; and the pleasurable pain, or painful pleasure, continues even where nothing is done, or can be done, towards mitigating the suffering', or even when there is no actual suffering at all. Linking this tendency to the 'parental instinct', which in Spencer tends to indicate the 'maternal instinct', he asked what was the 'common trait of the objects which excite' the feeling. He found that this common trait was

always relative weakness or helplessness. Equally in the little girl with her doll, in the lady with her lap-dog, in the cat that has adopted a puppy, and in the hen that is anxious about the ducklings she has hatched, the feeling arises in presence of something feeble and dependent to be taken care of.

Naturally, this extended to 'weakly creatures in general, and creatures that have been made weakly by accident, disease, or by ill-treatment' (*Principles of Psychology*, II, 688–92). This feeling, a tender sympathy, was a self-serving pleasure, compassion *de haut en bas*, that did not serve any far-reaching good.46 It accounted for what Gertrude Himmelfarb has called 'the corrupt version of the gift as practised by a lady bountiful'.47 Spencer called this 'ego-altruism'.48 New knowledge of the natural causes of the moral sentiments would bring this to an end and 'call in question the authority of those ego-altruistic sentiments which once ruled unchallenged'. The moral

sentiments, once fully evolved, were to 'prompt resistance to laws that do not fulfil the conception of justice, [and] encourage men to brave the frowns of their fellows by pursuing a course at variance with customs that are perceived to be socially injurious'.49 For physiologists and their supporters, antivivisectionist sympathy was deemed socially injurious in evolutionary terms and the pursuit of physiology was thought to be worth the frowns of (the less-evolved representatives of) society. Huxley perhaps said it most clearly when he wrote of the need of 'putting natural sympathy aside, to try to get to the rights and wrongs of the business from a higher point of view, namely, that of humanity, which is often very different from that of emotional sentiment'.50

Putting the moral good of vivisection in these terms, it now becomes clear that the utilitarian argument put forward in the defence of physiology — that vivisection was justified by its humanitarian ends — was precisely aimed at addressing the antivivisection claim that physiology had blunted the compassion of its practitioners. In fact it asserted a superiority of compassion apparently beyond the grasp of antivivisectionists.51 The argument was already strong without having recourse to the additional safety of anaesthetics, which, after the 1876 Bill to regulate their usage had passed into law, implicitly undergirded the majority of humanitarian claims put forward in favour of physiology.52

If the last quarter of the nineteenth century underwent a significant and general shift in the meaning and practical applications of compassion, as Gertrude Himmelfarb has convincingly argued in *Poverty and Compassion*, this article demonstrates that the adoption of a 'Religion of Humanity' was by no means uncontested. The intellectual and social impetus that drove 'humanitarians' to their 'Religion of Humanity' depended both upon the construction and direction of compassion, or sympathy more generally, and the degree to which 'natural-law' reconfigurations of moral action were set against prevailing notions of moral sentiments and aesthetic sensibilities. The encounter between compassion driven by an emotional/aesthetic response and compassion as an abstract judgement manifested two coeval and entangled 'moral economies': distinct webs of 'affect-saturated values' with their own systematized and normalized notions of right conduct.53

The analysis of this encounter allows us to understand why antivivisection agitation actually increased in the period after anaesthetic usage had been legislated, regulated, and monitored. Despite physiologists' untiring and consistent pleas that anaesthetics were used and were wholly effective in eliminating pain, antivivisectionists continued to protest in any case.54 These protests centred on the perceived moral danger of the image of the opened body and of the sight of blood, irrespective of the presence of pain. Stewart Richards has shown that

even after 1876, antivivisectionists found laboratory activities distasteful or repulsive, styling this as an 'aesthetic objection'. He explains that, even after anaesthetics had seemingly robbed antivivisectionists of their moral cause, the cause nevertheless continued on the basis of 'revulsion generated by the supposed aura of the laboratory as a hybrid product, as it were, of the operating room and the slaughterhouse'. Vivisection 'had become indelibly associated with ideas of ruthless interrogation, offensive air and, above all, with blood'.55 Antivivisectionists considered scientists to be just as brutalized by repeated exposure to the sight of blood as by their infliction of pain. This was a dulling of the aesthetic sense, of an instinctive sympathy, in societal leaders and public men, that might precipitate a general spread of brutality throughout society. The most ardent of antivivisectionists therefore saw the advance of physiology as the corrupt offshoot of Darwinian morals. 56 Frances Power Cobbe famously asked if

> the principles of the evolution philosophy require us to believe that the advancement of the 'noble science of physiology' is so supreme an object of human effort that the corresponding retreat and disappearance of the sentiments of compassion and sympathy must be accounted as of no consequence in the balance.57

Richard Hutton (editor of the *Spectator* and a leading antivivisectionist) thought that 'common compassion', the very thing that evolutionary ethicists had disavowed, had collided with 'the pursuit of scientific truth'. For him, 'the ends of civilization, no less than of morality' required that this common compassion, the aesthetic sense of sympathy, be followed.58 Indeed, the brutalized scientist himself, inured to the commission of painful acts and/or to the sight of blood, was the principal cause of antivivisectionist fear. Antivivisection's 'sentiment of distaste' — an 'aesthetic judgement' — was completely consistent with a judgement 'in universal (moral) terms'.59 An unfeeling man, judged by his insensitive eye, was an immoral man.

The antivivisectionist argument was sophisticated on this point. In allowing for a great expansion of animal experimentation, the legally enforced use of anaesthesia after 1876 was thought to have accelerated the numbing of the physiologists' own aesthetic sense. This risked their own, and ultimately everyone else's, moral sense. The first proof of this was, perhaps self-fulfillingly, in antivivisectionists' own treatment at the hands of medical scientists, which might be classified as disregard at best and hostile dismissal at worst. As a body claiming to represent public opinion, antivivisectionist fears were not activated principally by physiology's lack of feeling for animals, but by physiologists' apparent lack of regard for *them*, or for public feeling at large. Frances Power Cobbe feared that without instinctive disgust, hearts 'curarized' by 'science teaching' 'beat no more with any emotion of indignation or pity'. The institutional *raison d'être* of the Victoria Street Society, the principal organization opposed to vivisection, was to

> preserve the whole community [...] from the deadliest possible injury, namely, the suppression of compassion, and the

fostering of selfishness and cruelty, in the high places of education from whence those vices must permeate the whole character of the nation.60

Antivivisectionist outrage fits into a view, consistently held since Adam Smith's *Theory of Moral Sentiments* (1790), on what happens when compassion, or sympathy, is thought to have failed. It signalled the breakdown of civilization.61

Adam Smith, at any rate, would have understood antivivisectionist rage at physiologists' 'cold insensibility and want of feeling', but he would have also drawn the physiologists as 'confounded' at the antivivisectionists' 'violence and passion'. Indeed, the two camps had 'become intolerable to one another'.62 This failure was precipitated by the perception of science's increasing distance from public opinion, a novelty perceived in some quarters as the dangerous and immoral drift of society toward specialization and professionalization.63 Antivivisectionist 'pain' in the form of an aesthetics of compassion may have been irrational in utilitarian terms, but science's cold response was styled as inhuman. Civilization was risked not by vivisection, but by the character of the men who carried it out.

Physiologists departed from this position with the conviction, first, that aesthetically based moral sentiments could be flawed, and second, that evolutionary scientists better understood the highest ends of moral action. Compassion was projected to suffering humanity in the abstract and was out of place with regard to the sight/site of suffering in the laboratory, especially if there was actually no physical suffering. Those men who had already given preference to the cause of science over scruples about the infliction of pain, and the self-infliction of emotional pain, undoubtedly felt a greater release from the immediate aesthetic impulse of compassion, pity, humanity, or tenderness, through the use of anaesthetics. Moreover, anaesthetics allowed a great many further scientists to swell the ranks of physiology without the need to scruple about pain in the laboratory. This was considered to be an enrichment of the action of 'humanity', for it had humanity as a species as its object. Through this conception of humanity, the historian can more readily identify the imperturbable scientist, anaesthetized to the sight of blood, and callous for the sake of what he deemed a greater compassion.

'It is obvious that there is, beneath the electrode, a recording mechanism for memories of events. But the mechanism seems to have recorded much more than the simple event. When activated, it may reproduce the emotions which attended the original experience. What is more, the ganglionic mechanism continues to add to itself the memory of emotions which attend the recollection of the event and the substance of the man's reasoning regarding the significance of the event… 'The upon in the course of neurosurgical operations, and

which is probably duplicated in homologous areas of the two hemispheres, seems to have for its function the reproduction of (1) a remembered event or (2) thinking related to that event, and (3) the emotion it evoked' (Horowitz, 1997). I September 1953, Dr. William Beecher Scoville performed bilateral mesial temporal lobe resections on a patient known as H.M. in the medical records. The inadvertent severe damage to the important limbic structures resulted in permanent loss of memory in this patient (Scoville, 1957). H. M. knew his name. He knew that his father's family came from Thibodaux, LA, and his mother was from Ireland, and he knew about the 1929 stock market crash and World War II and life in the 1940s. But, he could remember almost nothing after that. Dr. Brenda Milner, professor of cognitive neuroscience at the Montreal Neurological Institute and McGill University studied H. M. almost up to his death in 2008 and noted: 'He was a very gracious man, very patient, always willing to try these tasks I would give him and yet every time.

Figures

References:

1. Michelle Weinroth and Paul Leduc Browne. Montreal: McGill-Queen's UP, 2008.2. Patrizia Guarnieri, 'Moritz Schiff (1823–96): Experimental Physiology and Noble Sentiment in Florence', in *Vivisection in Historical Perspective*, ed. by Nicolaas A. Rupke (London: Croom Helm, 1987), pp. 105–24 (p. 106).

3. Hilda Kean, '"The Smooth Cool Men of Science": The Feminist and Socialist Response to Vivisection', *History Workshop Journal*, 40 (1995), 16–38 (pp. 19, 23).

4. White's appraisal of the emotional control of physiologists is given richer treatment in 'Sympathy under the Knife: Experimentation and Emotion in Late Victorian Medicine', in *Medicine, Emotion and Disease, 1700–1950*, ed. by Fay Bound Alberti (Basingstoke: Palgrave, 2006), pp. 100–24.

5. Donald Fleming, 'Charles Darwin, the Anaesthetic Man', *Victorian Studies*, 4 (1961), 219–36.

6. J. Snow, *Blessed Days of Anaesthesia: How Anaesthetics Changed the World* (Oxford: Oxford University Press, 2008), pp. 155–58 (p. 164).

Article

Tasawwuf in the context of Folk Poetry

Khuraman Hummatova

Azerbaijan National Academy of Sciences,
Institute of Literature named after Nizami, Azerbaijan
hummatovax@mail.ru

Abstract

One of factors that increases magic of poetry of undying word master of azerbaijanian literature Imadeddin Nasimi(1369-1417)is his creative referring to folk literature.By this way master elevated poetic potential of azerbaijani turkish to unattainable heights and showed ,that azerbaijanian is a language of poetry as well as a language of "birds".Greatness of his mastery is that he could join with unparalleled cleverness divine idea with aestetic beauties in traditional structures of aruz poetical genres.Poetical strenght of Nasimi's poetry took its source from master's passionate poetical gift in one hand,but in another hand from national culture to which he was belonged.In this meaning,characters in Nasimi's creativity related not only with oriental hurufi views,but also with folk creativity,mystical folk views.Shouldered all ideological weight of stream which had got so monstrous social-geographical scale as hurufism,Nasimi at the same time didn't forget interests of literature,responsibility of it and has made irreplaceable contribution in development of azerbaijanian literature and poetry.

Keywords: folk poetry, tasaffuv, systemof images, hurufism

Introduction

Imadeddin Nasimi who had a great role in formation OF Azerbaijan philosophical poetry and the spreading of the hurufi movement was born in 1369 in an ancient city of of Azerbaijan, Shamakhi. Original name of the poet is Ali. He was named as Imadeddin (supporter of religion) as he profoundly knew the science of that period. He mainly wrote rhymes under pen name of "Nasimi". I. Nasimi's meeting with the founder of hurufism movement, Fazullah Naimi in 1386 was a milestone of the life of the poet. The poet studied the secrets of hurufism and was engageed in propogation of hurufism. He was torturely executed in 1417 in the city of Halab. The grave of the poet is visited as sanctuary.

His lyrical ghazals take the leading place in Nasimi's creativity. The conception of perfect person is brought forward in his poetry. According to the followers of hurufism, human being is a small part of the God, only perfect people would be able to join the God. Return of huan being to the God is the major criterion in the author's creativity. One of the source, the poet benefited was the folk creativity.

One of the factors increasing the value of magic of word of outstanding master of the Azerbaijan literature Imadedding Nasimi was benefiting from folk poetry. By this way, he rose up the poetic capabilities of Azerbaijan turkish languaget o the highest pick and also shown that the being of the language as language of poetry and "bird language". His might of mastership is that he could combine divine idea with ethic beauty at extraordinay level in the traditional structure of aruz genre of poetry:

The restless heart fallen again in the ghost of your eyes,

Who knows what my heart intends what it dreams

In this couplet, all fonological flexibility, poetic melody, the mechanisms of rhythmical expression of the Azerbaijan language came together. The couplets said centuries before are indicators stating that Nasimi was a poet of the azerbaijan language, who came off the heart of the very language and despite he used a formular-aruz rhyme of a foreign language which was strange from the national point he was never far away genetic formula of the vernacular language.

All historical beauty of colloqual and written arsenal of Azerbaijan poetry is reflected in these hemistiches which are the first couplet of the ghazal that could be assessed as a symbol of poetic beauty. It is not possible to construct these hemistiches without knowing the vernacular language, upgrowing in mother language and folk poetry environment.

The image "restless heart" used in the couplet directly came from the folk literature conntects the morale of the lyrical hero depicted in here with the deepest lays of thinking of the people of Azerbaijan. When the heart of Azeri turk-person becomes restless he turns to Deli Domrul (poetic image), Deli Qaraca (poetic image) (Kitabi Dede Qorqud). Nobody can make

an obstacle before his or her feelings erupting like mountainous river or like flood. A person of love like Dede Qorqud can turn these feelings into sounds, words, melodies and rhymes. From this point, the character "restless heart" and the psychological case expressed by this image indicates that Nasimi's unit existence and his psychological substance came up from the mentality of the people he belonged. The tuning of human feelings on morale features in Nasimi's rhymes sometimes leaves spots in his world of heart. The expression "restless heart" sometimes contains other features as well. "According to internal sympathy, in fact, the features of loosing value belong to human being. According to Tasaffuv vision, feelings like malice and hatred causes in gloominess of heart. That is called "rust" in tasaffuv poetry but in live language it is named as "distrustfulnes"." (1,136).

The poetic play-tejnis constructed with the omophors "khayalina" (your image) and "khayali" (dreamy) is not possible to be assesed as poetic construcion composed mechanically by a poet. It must be emphasized that the couplets given are the first couplet of the rhyme. That is a sign of poetic birth- it is manifest, came up extempore. The entire rhyme was constructed on this couple.

You deceitfully gret eyes deceived my heart,

Whoever falles in its trick, see what would happen.

The person who becomes captive of your eyes could understand me,

Let the person see his case who has not become your captive.

Nasimi forgot everybody since he found you,

He shrouded with you cloth and shawl rejecting pure silk (2, 43).

This rhyme discovers place and the role of the tasaffuv visions of that time which were depicted in Nasimi's creativity. There is a unique poetic structure in Nasimi's creativity which was set up on the basis of merging of tasaffuv and literature. In this rhyme, neither literature as expression of tasaffuv nor tasaffuv as idea expressed in literature leave each-other under shadow. That is to say, it is a fact, Nasimi, being a hurufi poet propagates hurufism ideologies. But there is a truth in this certain truth: Being a thinker of hurufism in his poetry, Nasimi is in love with literary words as well. While talking about the ideas he depicted in rhymes as hurufi thinker we shouldn't forget that Nasimi's literary identity (his poetry) was never placed at lower than his faith.

The lays of literature with tasaffuv in the rhyme can not be commented as a relation of content with form. In here, it would be simple to judge that meaning and literature form tasaffuv. Tasaffuv and literature form two lays of independent thinking. The topic could be in all cases about merging of the two lays with each-other reciprocally. Not only tasaffuv but

also literature itself is to be taken into consideration as idea to imagine it. Namely, there are lays of content and form of tasaffuv idea as well as literary idea.

If we entirely imagine this rhyme apart hurufism idea, then this rhyme would not loose anything from the excellence of its poetic structure. Because in here Nasimi didn't make literary plan depend on tasaffuv plan.The ghazal is a master piece serving to depict poetic-emotional cases expressing human beauty- face of beauty even without tasaffuv idea and its images.

At the same time, the rhyme represents tasaffuv idea by means of the system of figures serving entirely to depiction and expression. "(restless) heart", "dream", "eyes", "lip", "soul", "cheek", "(tasty) word ", "face", "eyebrow" etc. are lexical elements of depcting the world through tasaffuv. The "morale" of beloved is expressed, "secret" is commented, secrets of "beautiful face" are stated by these words and symbols.

Entire tassafuv expression of the rhyme serves to describe the morale of the beloved. A. Knish writes that, "the "way" of mystical in the morale" of souphi "in his psychology" towards the God is a situation fallen in irrespect to the level he reached in God's grip, in his willing and asceticism practice. (3, 266).

So, the ghazal which is mentioned, comprises incarnation of two structures in one structure- two rhymes in one rhyme.The first rhyme at first consists of content and expression plan dedicated to human beauty. That is an upper layer. The second rhyme consists of content and expression plan dedicated to the situation the beloved fallen in. That is the bottom layer. The combination of these two lays lifts Nasimi's poetry up to high level as well as against the background of his rhyme the reflection of appearanc of divine-cognitive of the world in the Azerbaijan poetry.

Besides obtaining poetic forms of the folk literature of Azerbaijan, Nasimi rose them to high contextual and form level. For ex, Qazi Burhaneddin noted down tuyugs in divine literature for the first time. The second poet who wrote tuyugs was Seyid Nasimi. The researchers are in impression that Nasimi was the most talented among the poets writing tuyug genres of poetry (4, 47).

It must be mentioned that, the approach of Nasimi to tuyuq genre is realized, assessed as his attitude to national literary genres. So tuyug genre is the only poetry shape used in divan literature by the national and turkish originated poets. He moved from the folk literature to the divine literature" (5, 108).

The master's tuyugs are significant in the classic Azerbaijan literature from th epoint of tasaffuv views that in these rhymes, literary form-tuyug genre never looses its genre features, poetic signs, with its high meanin at literary-ethics criteria level while turning to bearer of tasaffuv idea.

Long time your grieve is at me,

Heart is a person handcuffed to you.

Your leave knowked me down
You know my hope is with you (6 , 306).

There are purely love lyrics, real physical-psycological love at first sight as well as irphani ideas are expressed in the tuyug . The interest of the literature-the poetics of the genre was sacrificed to neither in the first outward hurufi loaded tuyug nor in the second esoteric loaded tuyug,on the contrary hurufi idea and national genre organicaly joint and served to the development of the literature.

The name of Nasimi's master (teacher), Fazullah Naimi is praised as Hurufi ideologist as well as poetic figure:

Fazl is truth, aware of secrets,
Our all lighted are from Fazl of the God.

Our duty was to show Fazl God,
Our creator is Fazl truth (6,21, 311).

Besides being knowing secrets, leading all hurufi idea bearers, building the world as an architecture, "Fazl-hak" is depicted as a poetic figure for making rhymes as anaphora.

Paying attention to moments expressing attitude in Nasimi's poetry contains importance. These moments besides expressing Nasimi's socio-psycological self-understanding, it demonstrates that on the ground of Nasimi's poetry Azerbaijan literature turned to self-understanding and on the whole submits the function of the grip:

The youth, who doubt about my being souphi?
Look at mirror if you are from people of pleasure?

The wise can not go towards the truth if he doesnt ovewhelm his passion,
Show an evident if you claim that you are from the people of Irphan.
A person having mind in this world whould say a lie.
What do you mean Nasimi, dont be that much unaware (6,21, 49-50).

Nasimi called his style of peotic creativity "bird language" due to complpexity as he used complex concepts, terms and tasaffuv-irphan symbols in his creativity. But his role in the development of the Azerbaijan language is very significant. The researchers particularly emphasize this point. According to M. Ozaydin, Nasimi's poetic language belonged to XIV century of the azerbaijan language and developed more, and was more precise and cleaner in comparison with Qazi Burhaneddin and Hasanoghlu. According to us, the biggest succes of Seyid Nasimi is that he used the turkish language as language of poetry in the XIV century. It is very hard to say the turkish language to have been used as language of poetry in Asia after Yunus Emre miracle late. It was Nasimi who first time created affect of poetry over the turkish language. (7, 272).

On the one side, Nasimi's source of poetic power is inspired from his pasionate poetry talent, on the other side it got power from national culture that he belonged. In these sence, the images used in Nasimi's crerativity were not only related to common eastern characterized hurufi meetings but also were related to the mythological meetings of the people. According to S. Shikhiyeva, while approaching to folk believes which were real protector of the views, Nasimi myth didn't track to elaborate the knowledges in this field and converted those into rhyme from the point of tasaffuv and hurufism (8, 20).

Inspite Nasimi was an outstanding hurufi idealogist, his poetry identity never melt or disappeared within the hurufism identity, Nasimi remained a figure of literature along his life and consciously served for the development of the common turkish literature. The notions used in the poetics of Nasimi's creativity confirms it too.According to I.Yakar, applying classical contents on the turkish as the 14th century classic turkish literature which could be considered as early, Nasimi masterly rose the notions of "word" in his poetry and caused in the defining of the divine poetry. The closeness between Nasimi and Fuzuli's styles, joint interests, poetic blocks and Fuzuli's imitative poems about Nasimi notify the closeness of their world view." (9, 115). Nasimi attempted to convey his thought by using adjectivess and metaphors like rhyme, poetry, word, logic, speech and to glorify his poets he used words like albumen, roll, jewel, drop, civility, shroff, truth, sweet, soul, water-life, kevser, revelation etc. (10,325).

"Nasimi was not only a hurufi but also he influenced to all literary environment as a master of poetry. Except Azerbaijan and Iranian poets, Ottoman poets even the uzbek poets respected and considered him as master of poetry. Even the opinion of an outstanding representative of the turkmen poetry Mahdumgulu about Nasimi and his critics about pealing of Nasimi's skin show the liteary power of Nasimi"(11, 42)

Conclusion

Nasimi' 's creativity is grandious from the point of literary capacity as well as from the point of senses existed in. Nasimi developed tasaffuv-irphan ideas in his creative works which were characteristic for middle aged history of Azerbaijan national thinking. The peculiarity of his creativity is that, besides taking the all responsibilities of hurufism ideology on his shoulders which expanded to a wide geographical space, he did never forget interests of literature and he contributed with his creative work to the development of the Azerbaijan poetry and the literary language.

References:

1. Shıkhıyeva S. Irfani-psikholoji paraleller. (Based on Nasimi's poetry). ANAS Institute of Oriental Studies. (publication V) Baku : 2003.

2. Nesimi. Composed by Hamid Arasli. Baku: Azerbaijan State Pulication House, 1973, 666 p.

3. Кныш А. «Кнал» (essay) / Islam. Encyclopedic dictionary. Msocow: Science, 1991, 266 p.

4. Ayan G. Seyyit Nesimi ve Tuyugları / Evrene Sıghmayan Ozan Nesimi (I International Simposium materials on Seed Nasimi, June17-19, 2005). Prepared by Gulagh Oz. Ankara: 2006, p. 47-50

5. Derdiyok Ch. Seyyit Nesimi ve Tuyugları / Evrene Sıghmayan Ozan Nesimi (International Simposium materials on Seed Nasimi, June17-19, 2005). Prepared by Gulagh Oz. Ankara: 2006, p. 108

6. Azerbaycan klassik edebiyyatı kitabkhanası. 20 volume. İ madeddin Nasimi. V volume. Composer of the volume Hamid Arasli;. Baku:Science, 1985, p. 368 p.

7.Shikhiyeva S. The place of mithopoetic images in Nasim's thinking / Sceintific researches (collection of scientific-theoretical articles), №3-4. Baku: Nurlan, 2000, p. 13-21

8. Ozaydın M. Seyid Nesimide Tasavvuf Anlayıshı / Evrene Sıghmayan Ozan Nesimi (First International Simposium materials on Seed Nasimi, June17-19, 2005). Prepared by Gulagh Oz. Ankara: 2006, p. 251-278

9. Alibeyli Sh. Nesimi ve Fuzuli sepkinde ortaq meqamlar (bsed on persian divines) / Evrene Sıghmayan Ozan Nesimi (First International Simposium materials on Seed Nasimi, June17-19, 2005). Prepared by Gulagh Oz. Ankara: 2006, p. 115-120

10. Yakar Ibrahim. Seyid Nesiminin Shiir Anlayıshı / Evrene Sıghmayan Ozan Nesimi (First International Simposium materials on Seed Nasimi, June17-19, 2005). Prepared by Gulagh Oz. Ankara: 2006, p. 324-338

11. Attar A. Hurufilighin Dini ve İ deolojik Boyutları ve Seyid Imadeddin Nesimi / Evrene Sighmayan Ozan Nesimi (First International Simposium materials on Seed Nasimi, June17-19, 2005). Prepared by Gulagh Oz. Ankara: 2006, p 28-46

LONG ISLAND UNIV, CW POST COLL, ISSN:0010-5716 UNITED STATES

Article

Causality and the cause of disorders miracles

James MIller.

Illinois Univers., USA
Miller.James010_@yahoo.com

Abstract

This emphasis continues to privilege a mythical vision of space, with terra Australis incognita reified according to either of two dominant paradigms: the landscape is cultivated as a blank space offering the egalitarian opportunity for 'man' to reassess and reassert 'his' place in the natural order; or the landscape is cultivated as a sublime object—grand, and at times terrifying in its vastness and emptiness, a spectral antipodean environment that seems to 'naturally' lend itself to the gothic mode.This essay begins from a simple premise: determinations of 'Australianness' and 'the Australian character' have been and continue to be inextricably linked to the fetishisation and reification of space in popular cultural manifestations of Australia. This is evident throughout white Australian cultural histories, as well as white histories of Australian culture. Perhaps this is a tautological claim in relation to any conception of nation; tied as such conceptions are to modern practices of cartography and geography. However, it is my contention that whilst notions of space play a determinant role in general vis-à-vis the configuration of nation (and national character), they play a larger role than usual in the configuration of 'Australia'; the function of space in the conception of Australia is less modulated through competing discourses such as class, ethnicity and religion than in other national examples.

Keywords: causality, causes, progress, contention

Introduction

I then argue in the second section that Justin Kurzel's recent horror thriller Snowtown, along with a handful of other Australian films, deliberately problematises this mythical representation of space in the bush-idyll and the Clarkeian gothic by depicting suburban space as the product of uneven geographical development; in Kurzel's film, space is gridded to the unproductive suburb, primed for the generation of violent, antisocial behaviour. Kurzel thereby aestheticises the argument of Gibson and Sloterdijk, demonstrating a socio-spatially-produced boredom with lethal consequences. Through its foregrounding of temporal cinematic effects, the film fetishises time and, in the context of its depiction of suburban marginality, reminds the viewer of the temporal dimension of political struggle as both unleashed through the unevenly urbanising forces of capital (Harvey 146-50) and repressed in the dominant depictions of space as either idyll or spectral landscape. Snowtown is thus a rare film in the Australian archive, suggesting Australia's spatial mythos obfuscates class exploitation, thereby challenging the myth of egalitarianism (linked to a perception of terra nullius, unbounded continental space) that continues to define much popular Australian discourse. On 28 June 1901, a 46-year-old French wood carver named Eugene N. was admitted to the London County Council's (LCC) Hanwell Asylum singing the Marseillaise at full throttle. In addition to boasting about his vocal talent and great riches, he repeatedly demanded to see the Queen, insisting it was his right as king. He was diagnosed with general paralysis of the insane (GPI), a disease associated with tertiary syphilis, which he had contracted as a young man. Scars believed to have been caused by syphilitic lesions were found on his body, confirming the diagnosis. According to his wife, who furnished the asylum authorities with details of her husband's history, Eugene had been 'a steady, temperate man, thoroughly moral, very industrious'. The following essay analyses these representations of Australian space in two sections. The first section discusses the spatial fetish in Australian culture in pre- and post-1788 European and Australian perceptions of terra Australis, through critical discussion of a selection of literary and cinematic artifacts. I follow a line of thought initially suggested by Ross Gibson in The Diminishing Paradise and later re-deployed by Peter Sloterdijk in In the World Interior of Capital that imagines cultural discourses about the antipodes and Australia as the product of a profound disappointment regarding the actuality of the Australian experience. In this reading, the terrestrialisation of the antipodean imaginary after invasion and colonisation—whether it be the optimism of the Patersonian bush-idyll, or the negative form signified by the Clarkeian gothic—has generated a diffuse sense of boredom that has

LONG ISLAND UNIV, CW POST COLL, ISSN:0010-5716 UNITED STATES

lingered in cultural artifacts across multiple media to the present day. At the same time, this fetishisation of space—'bush', 'beach' or 'outback'—continues to mystify nineteenth-century history: the massacres of Aborigines, convict abuse, the Squattocracy, and so on.

He had begun to suffer from dyspepsia and dilation of the stomach, poor eyesight, and 'sharp shooting pains in the legs' eight or nine years prior to admission. The 'extravagant ideas' had begun around six months before he arrived at Hanwell. Just two months after admission, Eugene was reported to have been 'pale and emaciated, continually talking to imaginary persons, making lunges at the wall, or jerking his hands in the air as if throwing off some imaginary objects on his body'. He frequently rubbed the skin on his knees and feet, all the while muttering 'electricity'. In November, five months after he was admitted, Eugene died. A post-mortem examination confirmed that he was 'tabo-paretic', suffering from tabes dorsalis and GPI, both of which could present during the tertiary stage of syphilis.1

Eugene's 'case' was included in a study of tabes dorsalis conducted by London pathologist Frederick Mott and published in 1903. In it, Mott claimed, among other things, that it was not uncommon for tabo-paretic patients to suffer from persecutory delusions or hallucinations that related to their bodily pain, writing:

These patients often believe they are being tortured by unseen agencies, that electricity has been turned on by their enemies; they have been given poison which has gone into their legs and feet. They may associate the pains experienced with dreams or visual hallucinations; and they may tell you [...] that lions and wolves came and gnawed their limbs by night, and will beg you not to let them be tortured again. (*AoN2*, p. 44)

Mott was not the first to have commented on this phenomenon. In his dictionary entry on locomotor ataxy, another diagnostic label for tabes, the Physician Superintendent at Bethlem Royal Hospital, George Savage, wrote thatcthere may be insane interpretations of the ordinary crises [...]. One man may attribute the pains and weakness in his legs to poisoning, or to 'influence' — electricity or mesmerism; while another will say the pain and thickening about his ankles are due to diabolical possession, and that the bullae [...] are marks of the devil's grip.2

Mott believed that these accounts were illusions, defined as 'a false interpretation of a sensation actually perceived', rather than delusions which the eminent Scottish alienist Thomas Clouston described as 'a belief in something that would be incredible to people of the same class, education, or race as the person who expresses it, the belief persisting in spite of proof to the contrary'.3 Because reports in asylum case notes were recorded as 'delusions', I shall use this term. Technically speaking, however, I agree with Mott. I believe that these accounts were, indeed, illusions, that is, erroneous interpretations of painful and bewildering bodily sensations and the agencies that caused them. As such, they can be analysed as pain narratives. This article

asks, therefore, what delusional themes can tell us about the subjective experience of pain in asylum patients with tertiary syphilis.

The historiography of syphilis is considerable but little work has been done on GPI and even less on tabes dorsalis.4 Substantive studies tend to focus on the more frequently diagnosed GPI. Psychiatrist Edward Hare produced a lengthy essay on its epidemiology, attributing its sudden rise in Europe during the nineteenth century to the proliferation of 'a special neurotropic strain of the syphilitic virus'.5 Juliet Hurn's doctoral thesis charts medical attitudes towards GPI in Britain from 1830 to 1950.6 The most recent and by far the most comprehensive work has been produced by social historian Gayle Davis whose monograph *The Cruel Madness of Love* traces the evolution of GPI as a disease category in a changing social, moral, and medical climate in Scotland during the late nineteenth and early twentieth centuries.7

None of these studies addresses pain because GPI was, in itself, rarely painful. Yet, tabes dorsalis, which often preceded GPI or coexisted with it as tabo-paralysis, affected the nervous system causing agonizing pain in virtually any part of the body, but particularly the legs, viscera, and head. Indeed, the broader topic of somatic pain in nineteenth-century asylum patients has received very little attention from historians, which is surprising given the lamentable physical and mental condition of so many inmates.

By arguing that delusions relating to bodily sensations can be construed as pain narratives, this article will add to the growing number of voices, including those of literary scholar Lucy Bending and cultural historian Joanna Bourke, who refute the much quoted claim by Elaine Scarry (1985) that 'physical pain does not simply resist language but actively destroys it'.8 While pain narratives do exist in myriad forms — often fractured accounts in diaries, letters, case-books, and medical journals — the voice of the historical patient-in-pain, particularly the socially disadvantaged patient, remains elusive. Following his clarion call to 'do history from below' in 1985, Roy Porter drew attention to delusional writings in a number of publications, thus demonstrating their historical value and ability to provide insights into the preoccupations and subjective world of people deemed to be insane.9Porter was intrigued by 'mad writings', commenting that 'there is no more splendid cache of psychopathological material than the delusions recorded over the centuries by the insane'.10 In *The Madhouse of Language*, literary scholar Allan Ingram has produced a sophisticated analysis of the language of madness drawn from accounts produced by the so-called mad, as well as the 'sane', recorded in medical records and texts, and in more literary works. He analyses language within the framework of linguistic and medical discourses of the long eighteenth

century to gain a deeper understanding of how today's critic or historian might understand the experience of madness. Drawing on the Lockean notion that madmen have wrong ideas but reason correctly, he writes that once the power of reason is granted, the articulations of madness can no longer be regarded as ravings or ramblings, but become available as linguistic acts to be read and understood within a system of grammar, and within a social system, just like any other.11

Ingram also connects language to the somatic experience of pain and, for this reason, his work has been particularly useful.

Most historical work on delusions has focused on first-person narratives in edited volumes and anthologies. These include Dale Peterson's anthology (1982), as well as a number of interpretations of the writings of London tea merchant James Tilly Matthews (1770–1815) and the German judge Daniel Schreber (1842–1911).12 Clinician and historian Allan Beveridge has drawn on accounts of delusions to provide insights into the psychological preoccupations of individuals through his study of patients who were admitted to the Royal Edinburgh Asylum between 1873 and 1908.13 Beveridge referred to these letters as 'bulletins from the front line', which are 'less tidy, less polished productions than published works [which][…] arguably […] give a more authentic picture of the nature of mental illness a hundred years ago' ('Voices of the Mad', p. 907). I will be making a similar point in relation to records in asylum case notes.

Few social and cultural historians have, however, tapped the rich seam of delusional content that was recorded in asylum case notes. There are good reasons for this. Literary scholar Carol Berkenkotter has shown how shifting psychiatric epistemology shaped the construction of asylum case notes, while social historian Jonathan Andrews has drawn attention to the potential pitfalls around working with these accounts, particularly relating to issues of inconsistency, omission, bias, and censorship.14 Case notes were usually written by doctors who might have been informed by nursing staff, the patient's relatives, or the patient, all with his or her own interests. The degree to which notes provide an insight into clinical 'reality' is, therefore, questionable because each will have been subjected to at least one stage of interpretation before the historian adds her own layer of reflexive interpretation to 'the mix'. Because we are trying to get closer to the patient's subjective experiences, rather than to that of the doctor, I will focus on the meaning of delusional *themes*, such as electricity, rather than provide a close textual analysis of the delusional accounts. Such themes, which are replete with symbolism, can be understood within a similar framework to that used for analysing metaphors, which imbue delusions with meaning, both describing and constructing experiences.15 While we can never really know for sure whether anomalous sensations were the result of tabes or neurological damage caused by other factors, we can be reasona-

bly sure of the GPI and/or tabes diagnosis because they were among the few, if not the only, conditions treated in mental institutions where lesions could be found at post-mortem.16

To summarize, this article sets out to ask what recorded delusions can tell historians about the subjective experience of pain in asylum patients with tabes dorsalis, thus exploring the complex relationship between culture, the body-in-pain, and the disordered mind. In terms of the structure, I will provide a brief overview of syphilis and GPI/tabes, and their symptoms, followed by a methodology for understanding delusional themes, applying this approach to that of 'electricity'. Finally, I will suggest the meaning given to pain by patients, how it was constructed, and some of the psychosocial consequences of these interpretations. First, however, it is important to understand tertiary syphilis within its social and historical context at the end of the nineteenth century.

Syphilis, GPI, and Tabes Dorsalis

Painful, horribly disfiguring, and incurable, few diseases were as socially freighted or feared as syphilis in Victorian Britain. Particularly prevalent in men, especially those who had served in the army or navy, it was cloaked in shame and stigma. Often referred to as 'the secret disease' or 'a social evil', syphilis was associated with 'sin'. During the latter decades of the nineteenth century, around five to seven per cent of those infected with syphilis developed diseases of the tertiary stages, which usually manifested as GPI, tabes dorsalis, or tabo-paralysis.17 At the time, a significant number of 'alienists', as nineteenth-century psychiatrists were called, believed that GPI and tabes could be caused not only by syphilis but by other pernicious effects of modern life; these included excessive alcohol consumption, tobacco, sexual indulgence, and over-work. By the end of the century, with degeneracy theory in the ascendency, most — but not all — alienists believed the underlying cause of GPI/tabes to be a faulty heredity, activated by syphilis. The aetiological link between syphilis and GPI/tabes was not proven in the laboratory until the early twentieth century following a chain of discoveries that began with the identification of the *treponema pallidum* as the causative agent of syphilis in 1905. A year later the Wasserman test was introduced to detect the bacterium in the blood and, in 1907, in the cerebro-spinal fluid. In 1913, it was found in the brain of a patient who had died from GPI.18

Incidences of GPI and tabes were particularly high in urban areas, with London numbers exceeding those of anywhere else in England and Wales. In 1901, no fewer than 17 per cent of male asylum admissions to LCC Asylums were diagnosed with GPI, compared to 11 per cent across England and Wales in a similar period. Death rates were even higher. General paralysis accounted for 38.5 per cent of male deaths in LCC asylums compared to 27.4 per cent nationally in 1901. The socio-economic consequences were significant, with most

LONG ISLAND UNIV, CW POST COLL, ISSN:0010-5716 UNITED STATES

deaths occurring in men aged 35 to 54 when many were at their most productive. The wealthy — and it was common in men from all social classes — could afford to be looked after at home or in a discreet private nursing establishment, thus evading the social stigma associated with asylums, as well as the statistics. Tabes and GPI were diagnosed far more infrequently in women: 3.3 per cent in London compared with 2.4 per cent nationally in 1901, although this percentage did begin to rise in the early twentieth century.19 Some contracted it through prostitution, others from their husbands.

Recording a diagnosis could be a vague and arbitrary affair. On admission, most patients with both tabetic as well as paretic symptoms were given a primary diagnosis of GPI, as in the case of Eugene N. As the disease progressed, tabetic symptoms might diminish while paralysis and dementia associated with GPI became more pronounced, ultimately leading to death. Mott circumvented the GPI/tabes distinction by using the term 'tabo-paralytic', claiming that many of the leading authorities on the subject believed that 'etiologically and pathogenetically the two diseases were identical'. He maintained that 'there is one tabes which may begin in the brain [...] or in the spinal cord [...] or in the peripheral nervous structures' connected with different parts of the body (*AoN2*, p. 3). By the 1920s, all forms of tertiary syphilis that affected the nervous system, including tabes dorsalis and GPI, were included within the umbrella category of neurosyphilis (Davis, p. 16). Not only was the prospect of an accurate diagnosis confused by myriad symptoms, it could also be influenced by a patient's social class due to the delicate nature of his condition. While county asylum patients were diagnosed with general paralysis, Mott wrote that 'when a noble or distinguished patient suffers from grandiose delusions and other signs of the progressive brain disease which in a few years will terminate fatally, it is given out that he is suffering from locomotor ataxy' (*AoN2*, p. 3). Whatever the diagnostic label, those suffering from these forms of tertiary syphilis faced an incommutable death sentence. Months or years of excruciating and debilitating pain in the case of those with tabes were often followed by the gradual deterioration of body and mind that required intensive nursing care in the GPI wards of a mental establishment.20

Not only did confusion around diagnostic categories prevail, so, too, did symptoms. Syphilis was often referred to as 'the great imitator' or 'great imposter' because it could so easily be confused with other conditions. Many sufferers believed for years that the pains in their legs were sciatica or rheumatism, or that they suffered from gout (*AoN2*, pp. 42–43). Indeed, it was not uncommon for tertiary syphilis to be diagnosed fifteen or twenty years after the initial infection, having remained latent in the body during the intervening period. In the case of tabes or tabo-paralysis, the syphilitic spirochaete caused degeneration and inflammation of the dorsal, or posterior, column of the spinal cord, giving rise to a number of symptoms. Mott enumerated the main ones as reflex pupil rigidity (Ar-

gyll Robertson pupils); lightning pains, absence of deep reflexes; visceral disturbances, bladder troubles, and gastric crises; motor disturbances; and mental disturbances (*AoN2*, p. 30). He wrote how patients with tabes dorsalis suffered from agonizing pain with pin-point pupils, citing the case of one woman for whom 'even the light of the windows was so painful she would bury her face in the pillow' (*AoN2*, pp. 31, 43). Abdominal or 'girdle pains' were common, described by Mott as a 'tightness compared to an iron jacket or the constriction of a tight belt', and by one of his patients as if 'something was squeezing him in a vice' (*AoN2*, pp. 43, 122). Another patient experienced a burning pain in the larynx and felt he was going to be suffocated (*AoN2*, p. 57). A common early symptom of tabes was lancinating pains which Mott likened to 'stabbing, shooting, boring or lightning, or to hot wires thrust into the flesh' (*AoN2*, p. 42).

GPI tended to be associated with dementia and paralysis of virtually any part of the body. In itself, it does not cause pain. Even when pricked by a needle, GPI patients were reported to feel — or, at least, complain — very little due to the partial destruction of the cerebral cortex, which processes sensory information (*AoN2*, p. 312). However, while a patient may have been diagnosed with GPI, he may also have suffered from the painful symptoms of tabes, even at the advanced stages of the disease. Mott wrote that

> many of the tabetic cases of very old standing still suffer with the lightning pains and visceral crises. All the while there are any rootlets left undestroyed by the disease, pains may occur and radiate all through the sentient grey matter, each decaying fibre serving as a fulminating agent. (*AoN2*, p. 79)

Not all tabetic patients developed GPI and its associated mental symptoms, which invariably resulted in admission to an asylum. Patients who escaped this fate were usually As is so often the case with hallucinations and delusions, whatever their aetiology, those associated with the pain of tabes were frequently frightening, persecutory, and condemnatory. Mott cited the experiences of a male patient, referred to as F. W. R., who was a 35-year-old clerk, admitted to Claybury Asylum in 1899, believing two nurses were following him around, talking about him, turning on electricity, and pulling his legs at night. The patient reportedly associated the lightning pains and cramp-like spasms with the voices. He claimed one nurse caused him

> to have electric shocks in his limbs, body, and face. They pull his bowels about, and caused him to have pains at his heart; some time ago they continually put poison into his rice pudding, which burnt the inside of his stomach. (*AoN2*, pp. 82, 118–19)

Mott recounted another case of a musician who suffered from lightning pains and heard an orchestra which

he associated with the electric wires and electric currents in his body [...] and being a professional flute player, he whistled very accurately the melody he heard in his mind, and was quite surprised that I did not hear it also. (*AoN2*, p. 83)

Another case was a dock labourer who was admitted to Claybury aged thirty-five having suffered for years from what he believed to be pains caused by rheumatism and indigestion. 'After three years he had delusions of persecution, that unseen agencies turned on electricity and blew up his stomach', Mott wrote (*AoN2*, p. 56). In 1901, Elizabeth H, a 51-year-old woman, was admitted to Hanwell tied to a stretcher and in a maniacal state with conjugal paralysis. She claimed to 'see Old Nick' and that 'Burglars came into the house, they boiled the pot and then poured it down her throat' (*AoN2*, pp. 242–43). Her case notes record that she believed her 'arms, knees & legs are diseased and that she has the "black pox"'.21 George Savage explained how one patient would claim that his bowels had been twisted by his persecutors, while another stated that red hot irons had been thrust into his feet and eyes. Other tabetic patients have been recorded as saying that worms were eating their insides out, that lions wanted to devour them, or that snakes were living inside them. These delusions clearly signified extreme psychic distress as well as physical pain. Sufferers were in the grip of an existential crisis as they grappled with the symptoms of a painful and socially stigmatized disease that would almost certainly end in an ignominious asylum death. The next section looks, therefore, at how recorded delusions might provide us with deeper insights into the patients' experience of bodily pain.

Delusions and their Meanings

What, then, can delusional themes tell us about the meaning given to pain by tabetic patients? First, we know that the experience of pain is formed by the embodied consciousness and theories of the body and mind in any given culture at any given period of time.22 'The subjective character of experience (its phenomenological content)', Joanna Bourke has written, 'does not simply arise from interactions in the world but is constituted by those interactions' (*Pain and the Politics of Sympathy*, p. 14). People's experiences of their bodies are shaped by a range of cultural and societal influences from 'language and dialect, power relations, gender, class and cultural expectations, climate, and the weight and meaning given to religious, scientific and other knowledges' (*Pain and the Politics of Sympathy*, p. 18).

In his ground-breaking book, *The Illness Narratives*, cultural anthropologist and psychiatrist Arthur Kleinman states that 'cultural meanings mark the sick person, stamping him or her with significance often unwanted and neither easily warded off nor coped with. The mark may be either stigma or social death.' He adds: 'The cultural meanings of illness shape suffering as a distinctive moral or spiritual form of distress.'23So, whether or not somatic pain is triggered by a physiological event, such as a lesion caused by disease or injury, the experience is constructed in a complex web of social, cultural, psychological, and physiological interactions. 'Even when suffering,

people adhere to societal norms, rituals, and stories', explains Bourke (*Pain and the Politics of Sympathy*, p. 6). This is where metaphors play such an important role. Making conceptually elusive physical sensations, such as pain, more psychologically tangible enables individuals both to understand their subjective experiences within their own terms and to communicate them.24 Metaphors expand the systems of knowledge and belief from which they evolve, creating new meanings and experiences. For example, new findings in the field of bacteriology in the late nineteenth century gave rise to metaphors relating to the 'invasion' of the body by recently discovered pathogens. War metaphors became common in the early twentieth century. Salvarsan, the first chemical treatment for syphilis, discovered in 1909, was referred to as a 'magic bullet' (Brandt, p. 40).

Like metaphors, delusions are culturally constructed in terms of both their form and their content.25 The psychologist Brendan A. Maher hypothesized in 1974 that 'many paranoid patients suffer not from a thinking disorder but from a perceptual disorder' and that in the case of experiencing an unusual bodily sensation 'the patient is not presenting a delusion in any technical sense. He is describing an experience.'26 Maher continued: 'A delusion is a hypothesis designed to explain unusual perceptual phenomena and developed through the operation of normal cognitive processes' (Maher, p. 103). This takes us closer to the notion that somatic delusions can be misperceptions of bodily sensations. Broadly speaking, Mott and his late nineteenth-century colleagues were saying the same thing. Tabetic patients encountering the unannounced, the abrupt, the short sharp shocks, and the long sharp shocks of tabes dorsalis created narratives that were intended to be literal descriptions, yet were imbued with metaphor that helped them to make sense of their pain, thus shaping their phenomenological experience.27 Attributing painful sensations to electric currents, the work of devils, or attacks by wild and untamed animals transformed bewildering and frightening sensations into experiences that could, as Bourke has contended, be understood by the patient within his or her world view. This is not to say that this process enabled the patient to control their pains, even though they tried to by lashing out at the imagined attacker. But it did help them to understand them better, to comprehend that they could *not* restrain or manipulate these forces because, like electricity, devils, and wild animals, they were beyond human control. In his study of 'mad writings', Ingram has written that to find meaning in their pain, pain sufferers might develop a language that will allow them to 'negotiate' it (Ingram, p. 106). Maher commented that

> when a coherent explanation is ultimately developed, it should be accompanied by a strong feeling of personal relief [...] even if the explanation is [...] threatening to the patient: the kind of relief associated with 'Now I know the worst,' may

temper the ominous implications of the explanation itself. (Maher, p.104)

There is a crucial distinction between how those with and without delusions respond to metaphorical associations. This lies in the system of belief surrounding them. The person who is not experiencing delusions consciously employs metaphor as a linguistic device to describe and give meaning to a sensation; the individual with delusions describes — and might act on — what he or she *believes* to be a real event. Asylum superintendent W. Julius Mickle, who wrote extensively on GPI, described one patient who,

when walking quite alone, and when absolutely unmeddled with, was accustomed to shriek suddenly at times, and when questioned on the subject declare that someone had that moment kicked or injured him, or that his back was broken.28

This draws attention to another difference between delusional and non-delusional narratives of pain. Tabetic patients with delusions provide an insight into somatic pain *as they were experiencing it*, rather than after the event.29 The French novelist Alphonse Daudet (1840–1897), who suffered from tabes dorsalis without mental symptoms, made extravagant use of metaphor in his notebook *La Doulou* where he described in detail his excruciating pains.30 He wrote that 'words come only when everything is over, when things have calmed down. They refer only to memory, and are either powerless or untruthful' (Daudet, p. 15). Ingram reinforces this point: 'The here and now is [...] a vital ingredient of this kind of mad language. Madness is in a perpetual present, and makes of the past only what can contribute to the chosen explanation for the reality of pain' (Ingram, p. 117). Delusions that are triggered by somatic sensations do, therefore, provide narratives of pain that are not self-consciously mediated by the sufferer, providing deeper insights into direct experiences.

Interpretation

Understanding the subjective meaning patients gave to their pain experiences requires a deeper exploration into why particular themes gained traction and agency within delusional systems. An obvious starting point for embarking on an interpretative analysis of the delusional themes is, therefore, to briefly outline prevailing cultural attitudes in Britain towards syphilis. Primary stage symptoms include painful ulcers and chancres, particularly on the genitals, as well as boils and buboes filled with foul-smelling pus. Unsurprisingly, biblical tropes abounded. As did references to other stigmatized diseases such as plague, which was associated with transmission by rats and fleas, and, in turn, with filth and defilement. In March 1891, a *Daily Telegraph* editorial famously commented on the one and only performance of the first British production of 'Ghosts', in which the Norwegian playwright Henrik Ibsen confronted social attitudes towards syphilis. The review was excoriating, describing the play as 'an open drain; a loathsome sore unbandaged; of a dirty act done publicly; or of a lazar-house with all its doors and windows open'.31

Syphilis had, therefore, become a powerful metaphor in itself. Historian Lesley A. Hall has suggested that by the end of the century 'the "guilty" sufferer [...] was more often perceived as male, conveying disease to his innocent family, as opposed to a contaminated prostitute infecting healthy young male bodies' (Hall, p. 123). Similarities between the social meaning and clinical manifestation of AIDS and syphilis have received a great deal of attention from scholars across disciplines. Susan Sontag's essay, 'AIDS and its Metaphors', is among the most notable. Here, she explains how, historically, epidemics such as plague were often believed to be inflicted by God as a punishment, writing: 'Thinking of syphilis as a punishment for an individual's transgression was for a long time, virtually until the disease became easily curable, not really distinct from regarding it as retribution for the licentiousness of a community.'32 Parallels were drawn, both implicitly and explicitly, between the syphilitic spirochaete infecting the body and the notion of a social pathology in which the carriers of syphilis contaminated society. Gayle Davis has noted how one paretic patient in a Scottish asylum would stay clear of other patients lest he might infect them with syphilis, commenting how 'a number of those patients who knew or at least believed themselves to be venereally infected were said in their case notes to feel similarly dirty and infectious' (Davis, pp. 101–02). This explains the alienating effect of syphilis, which, in the tertiary stages, conflated social with mental isolation as patients descended towards madness and death, ministered to by asylum 'alienists'.

Returning to the punishment theme, the notion of 'pain as torture' has commonly been evoked by pain sufferers, whatever the cause of their pain and whether or not they were psychotic. Tabetic patients were no exception. Mott remarked on how the insane tabetic might believe that 'enemies are torturing them with electricity', or with 'hot irons and pincers before electricity was in general use' (*AoN2*, p. 37). Hot irons and pincers did, therefore, retain their symbolic value as instruments of torture, even though the practice had been outlawed in England more than two centuries earlier. Yet, as in the case of patient F.W.R., who believed nurses were turning electricity on in his legs, clinical staff were not always seen as benign. Indeed, it is possible that the notion of pain-as-punishment was psychologically appropriated by patients because hot irons had been used by physicians to cauterize syphilitic chancres in an agonizing and invasive procedure (Quétel, p. 117). Other potentially punitive 'treatments' included mercury, which could make symptoms worse and result in a number of unpleasant and painful side effects.33 Cultural historian Judith Walkowitz has pointed out that 'despite the new humanitarian spirit in medical practice [...] mercury application was very painful, it remained an appropriately punitive method of treating syphilitics'. She suggests that treatments may have contin-

ued after the subsidence of the symptoms to discourage the sufferer from 'further immoral activities' (Walkowitz, p. 55). Indeed, American actuarial tables from the early twentieth century show that the mortality rates of people who were untreated for syphilis was lower than those who had been treated with mercury.34 Other medical interventions that could have led to misinterpretations of bodily sensations were sensory tests in which patients were pricked with needles or subjected to electrical currents to see whether or not they would respond to pain (*AoN2*, p. 243). It is no wonder, then, that delusions of persecution implied a threat of attack from an agency that worked either directly on the body, such as electricity, or that was inflicted by an external force, be it a doctor, a nurse, or the devil.

Electricity was a common delusional theme expressed by asylum patients suffering from a range of mental and physical conditions, including tabes and tabo-paralysis. From the latter decades of the eighteenth century and during the course of the nineteenth century, electricity gained increasing purchase on descriptive language and delusional themes. From the late-Georgian era, it was used to describe the body's biomechanical systems, as well as somatic sensations. Similarities between physiology and electrical events began to be investigated, and experiments in electrophysiology were conducted.35 Wider curiosity among a lay readership was piqued in 1818 by the publication of the highly popular novel *Frankenstein*, in which the author Mary Shelley 'shocked' her creature into life using the force of electricity. As a discipline, neurology emerged during the second half of the nineteenth century in tandem with the growing understanding and application of electricity brought about by the Second Industrial Revolution. Not only did electricity provide a fertile source from which new metaphors — 'current', 'shock', 'spark', 'pole', 'circuit', 'plug', 'energy', etc. — could be created, enabling experiences and events to be conceptualized differently, but it shaped ways in which the body was understood. Cultural historian David Nye has written how during the nineteenth century 'Americans internalized a new psychology in which the human personality was an electrical system that could be "switched on", "overloaded", "short-circuited", "shocked" and "burned out"'.36

Electricity was also valued for its therapeutic benefits. From the 1830s, galvanism was used to stimulate the nervous system — calming, stimulating, ameliorating pain, and producing contractions.37 Gout, rheumatism, sexual and urinary dysfunctions, as well as neuralgia and neurasthenia, were all considered treatable by this new technology. Newspapers and periodicals ran advertisements promoting electric belts for men and corsets for women, associating it with life and virility — force, energy, and strength.38 But there was also a dark side to electricity. Few people understood how it worked and for many it was silent, undetectable, and potentially deadly. Furthermore, it gradually began to be incorporated into the structures of a growing number of public and domestic buildings, including asylums. Fears around its dangers were

stoked by the gas industry seeking to quash the competition.39 People believed that, like gas, electricity would explode (Gooday, p. 72). In 1881, Irish labourers laying electric cables in New York were terrified of 'the devils in the wires'.40 Yet these fears were not commensurate with the actual number of electrical fatalities, which were rare. When they did occur, the press had a habit of sensationalizing them.41

Perhaps nothing aroused fears around electricity more than reports of the first execution by electricity that took place in New York in August 1890. William Kemmler faced the chair for killing his lover, Lillie Zeiger, under the influence of alcohol. Both Zeiger and Kemmler had been married and were referred to as 'the guilty couple', implying that Kemmler was paying the price not only for murder but for adultery, sexual incontinence, and drunkenness, behaviours that were, incidentally, believed to cause syphilis during that period. The British press had a field day. Headlines such as 'The First Electric Execution. Terrible Scenes' or 'The Electric Death' enticed readers into reports of 'contortions of the body', 'frothing at the mouth', and 'a sickening smell of burning flesh and hair'.42

Electricity could, therefore, be perceived in a positive or a negative light. This, as cultural critic Tim Armstrong has explained, created a duality in attitudes to electricity as both a life force and a killing instrument, in addition to being 'part of the emerging technologies of medical control' that provided a '"clean" way of solving the problem of transgressive behaviour' (Armstrong, pp. 14, 32). Electrocution created 'a chastisement of the body which silently and invisibly absorbs the individual into a scientific and technological system', he has argued (Armstrong, p. 34). Electricity is a fatal and silent force: sterile, sterilizing, cauterizing, invisible, causing death without warning.

An analogy can be drawn between popular perceptions (and misperceptions) of the properties of electricity and syphilis, both of which exist or are able to exist in the body undetected. Some patients who developed GPI or tabes may have been surprised to discover that a syphilitic infection had remained in their system years after the primary symptoms had disappeared. Others would have been fully aware that they ran the risk of developing tertiary symptoms when the spirochaete might attack the brain, the nervous system or both, suddenly and unannounced. The lancinating pains that shot through the limbs were often described as 'lightning' pains; like electrical charges flashing through the sky, they were imbued with their own sense of agency or believed to have been sent as a punishment from God.

When these attacks took place, Mickle commented that male tabetic patients would 'shriek' with pain, a word described in 1911 as 'shrill & usu. inarticulate cry of terror, pain, &c., screech, scream; laugh uncontrollably […] say in shrill agonized tones'.43 This, of course, was Mickle's term, and one he used frequently, which

gives insight into his own perception of the experience and response to pain in male patients.44 'Shrieking' in this context implies surprise, shock, an unexpected and frightening event, or 'hysterical' which suggests a female quality. Did this mean that men with tabes and tabo-paralysis felt emasculated by their condition? Mickle commented that the gait of one patient who had previously been in the army had become 'slouching and unsoldierly' (Mickle, p. 62). Daudet commented that his 'resort to anaesthetics is like a cry for help, the squeal of a woman before danger actually strikes' (Daudet, p. 9). Lucy Bending has interpreted this as evidence of a 'kind of failure of masculinity' ('Approximation', p. 133). Indeed, in an era when independence was valorized, the sight of other patients growing increasingly demented, paralysed, and helpless must have caused great anguish in men who had recently been admitted to paralysis wards and were still able to perceive their surroundings. It was a far cry from the hubristic delusions of grandeur many had manifested during their admission to the asylum.

Conclusion

This article is predicated on the premise that, in some cases of tabes dorsalis, delusions were misperceptions of bodily sensations and can be analysed by historians as pain narratives, thus providing insights into patients' subjective experiences. In particular, it draws attention to the degree to which somatic and psychic pain are inextricably intertwined, their boundaries hazy and porous. As Mott wrote: 'In tabo-paralysis, in the early stages, there may be an intensification of the pains and sufferings by the subjective attitude of the individual towards the effects produced by the irritation and degeneration of the sensory, somatic, and visceral neurons' (*AoN2*, p. 312). As the patient finds himself subsumed by an existential crisis of cataclysmic proportions, helplessly and hopelessly 'battling' society's most stigmatized disease, knowing, as far as he is able, that an ignominious and undignified death awaits him, his sense of shame and alienation, in every sense of the word, permeates these fractured pain narratives.

Here, I have drawn on delusions experienced by a small sample of asylum patients who were in the last stages of their life. They were mainly male, living in London *circa* 1900, and witnessing a period of massive change: faith in new powers (science and industry) was challenging old beliefs (God and religion); and when newly identified pathogens became the enemy, purity movements were mobilized to fight them on all fronts. If these delusional themes are compared with those experienced by other patients suffering from the same pathology and symptoms in another time period or culture, we would be confronted with a different pattern of themes and, thereby, experiences of pain. This is a bigger project consciously created to describe a physiological event, sometimes for the sake of posterity when used in a personal diary or journal. Even though they shaped experiences, the writer understood them for what they were, linguistic devices, and did not believe them literally to be true. Delusions were intended to be descriptions

of real events; they were constructed out of metaphors to help patients make sense of and even negotiate their pain. Tabetic patients were existentially, psychologically, and physically invested in their delusions, fighting for their life, the only group of asylum patients suffering from a known psychopathology with fatal consequences. Mott said as much himself when he wrote that the tabetic with delusional insanity [...] probably suffers more than the sane tabetic, as he is not only tortured with physical pain, but also with delusions of persecution by unseen agencies — the true pains forming a realistic basis to the delusions around which his whole psychical existence may centre. (*AoN2*, p. 44)

'Pain', according to clinician and literary scholar David Biro, 'is an all-consuming internal experience that threatens to destroy everything except itself — family, friends, language, the world, one's thoughts, and ultimately even one's self.'45 Through their delusional systems, asylum patients attempted to give meaning to their pain, transforming it into a tangible entity they could fight, or starve, or stifle. And this allowed them to cling to their sense of self for as long as possible — to challenge, to resist, to battle on before the *treponema pallidum* did its worst, rendering them totally helpless.

References:

1. Hanwell Asylum, Male Case Book 20, case 10,532, ff. 573–74, London Metropolitan Archives (LMA), H11/HLL/B/20/029. Where possible, I have compared Mott's notes with the asylum case notes for individual patients, quoting the latter where discrepancies exist between the two.

2. 'Bullae' are bed-sores. Geo. H. Savage, 'Locomotor Ataxy, Tabes Dorsalis, Ataxie Locomotrice Progressive', in *A Dictionary of Psychological Medicine*, ed. by D. Hack Tuke, 2 vols (Philadelphia: Blakiston, 1892), II, 750, bold in original.

3. 'Illusion', in *A Dictionary of Psychological Medicine*, I, 675; T. S. Clouston, *Clinical Lectures on Mental Diseases*, 3rd edn (London: Churchill, 1892), p. 244.

4. Roger Davidson and Lesley A. Hall (London: Routledge, 2001); John Parascandola, *Sex, Sin and Science: A History of Syphilis in America* (Westport, CT: Praeger, 2008); and Claude Quétel, *History of Syphilis*, trans. by Judith Braddock and Brian Pike (London: Polity Press, 1990).

5. E. H. Hare, 'The Origin and Spread of Dementia Paralytica', *Journal of Mental Science*, 105 (1959), 594–626 (p. 595).

6. Juliet D. Hurn, 'The History of General Paralysis of the Insane in Britain, 1830 to 1950' (unpublished doctoral thesis, University of London, 1998).

7.

LONG ISLAND UNIV, CW POST COLL, ISSN:0010-5716 UNITED STATES

Gayle Davis, *'The Cruel Madness of Love': Sex, Syphilis and Psychiatry in Scotland, 1880–1930* (Amsterdam: Rodopi, 2008).

8. Lucy Bending, 'Approximation, Suggestion, and Analogy: Translating Pain into Language', *Yearbook of English Studies*, 36 (2006), 131–37; *The Representation of Bodily Pain in Late Nineteenth-Century English Culture* (Oxford: Clarendon Press, 2000); Joanna Bourke, *Pain and the Politics of Sympathy, Historical Reflections, 1760s to 1960s* (Utrecht: Universiteit Utrecht, 2011); Elaine Scarry, *The Body in Pain: The Making and Unmaking of the World* (New York: Oxford University Press, 1985), p. 4.

9. Roy Porter, 'The Patient's View: Doing Medical History from Below', *Theory and Society*, 14 (1985), 175–98.

10. *The Faber Book of Madness*, ed. by Roy Porter (London: Faber and Faber, 1991), p. 131. See also by Porter: *Mind-Forg'd Manacles: A History of Madness in England from the Restoration to the Regency* (London: Penguin 1990), ch. 5; *A Social History of Madness: Stories of the Insane* (London: Weidenfeld & Nicolson, 1987); and John Haslam, *Illustrations of Madness*, intr. by Roy Porter (London: Routledge, 1988).

11. Allan Ingram, *The Madhouse of Language: Writing and Reading Madness in the Eighteenth Century* (London: Routledge, 1991), pp. 6–8.

12. *A Mad People's History of Madness*, ed. by Dale Peterson (Pittsburgh: University of Pittsburgh Press, 1982); Mike Jay, *The Air Loom Gang: The Strange and True Story of James Tilly Matthews and his Visionary Madness* (London: Bantam, 2003); Eric L. Santner, *My Own Private Germany: Daniel Paul Schreber's Secret History of Modernity* (Princeton: Princeton University Press, 1996).

13. Allan Beveridge, 'Voices of the Mad: Patients' Letters from the Royal Edinburgh Asylum, 1873–1908', *Psychological Medicine*, 27 (1997), 899–908; see also 'Metaphors of Madness: Iain Crichton Smith's Journey through the Inferno', *History of Psychiatry*, 7 (1996), 375–95.

14. Carol Berkenkotter, *Patient Tales: Case Histories and the Uses of Narrative in Psychiatry* (Columbia: University of South Carolina Press, 2008); Jonathan Andrews, 'Case Notes, Case Histories, and the Patient's Experience of Insanity at the Gartnavel Royal Asylum, Glasgow, in the Nineteenth Century', *Social History of Medicine*, 11 (1998), 255–81 (p. 280). See also Guenter B. Risse and John Harley Warner, 'Reconstructing Clinical Activities: Patient Records in Medical History', *Social History of Medicine*, 5 (1992), 183–205.

15. This draws on the ground-breaking work by George Lakoff and Mark Johnson, *Metaphors We Live By* (Chicago: University of Chicago Press, 1980).

16. There is, of course, also the possibility that their pains were caused by other physical diseases such as tuberculosis, or that they were suffering from psychogenic pain. It is not unusual to find descriptions of tabetic pain described in non-delusional terms, usually at early stages of the disease.

17. The actual percentage of men with syphilis who went on to develop diseases associated with its tertiary stage is difficult to ascertain. Julian Barnes has suggested that it was five to seven per cent. Alphonse Daudet, *In the Land of Pain*, ed. and trans. by Julian Barnes (New York: Knopf, 2002), p. 82.

18. Davis, p. 203. GPI was identified following the discovery of cerebral lesions by the French physician Antoine-Laurent-Jesse Bayle in 1822. By the 1860s, it had been accepted as a distinct disease within its own right with an 'identifiable brain pathology, predictable clinical history and a definite correlation between these two elements' (Davis, pp. 84–85). Tabes dorsalis — meaning wasting of the dorsal column of the spinal cord — was identified in the 1840s by the German neurologist Mauritz Romberg.

19. *LCC Thirteenth Annual Report*, 1902, p. 187, LMA; *Fifty-Sixth Report of the Commissioners in Lunacy to the Lord Chamberlain*, 1902, pp. 130, 152.

20. Most asylum patients died within two years of admission. Some lived far longer, while others went into remission and were discharged.

21. Patient details are drawn from the asylum case notes. Hanwell Asylum, Female Case Book 26, ff. 511–12, LMA, H11/HLL/B/19/049.

22. The Birkbeck Pain Project, 'Rhetorics of Pain: A Transcultural History of Bodily Pain from 1760–1960', in *Pain: Management, Expression, Interpretation*, ed. by Andrzej Dańczak and Nicola Lazenby (Oxford: Inter-Disciplinary Press, 2011), pp. 67–73 (p. 67).

23. Arthur Kleinman, *The Illness Narratives: Suffering, Healing & the Human Condition* (New York: Basic Books, 1988), p. 26.

24. Deborah Lupton, *Medicine as Culture: Illness, Disease and the Body in Western Societies* (London: Sage, 1994), p. 55.

25.Richard P. Bentall, *Madness Explained: Psychosis and Human Nature*(London: Penguin, 2004), p. 130.

26. Brendan A. Maher, 'Delusional Thinking and Perceptual Disorder', *Journal of Individual Psychology*, 30 (1974), 98–113 (pp. 99, 102).

27. J. E. Rhodes and S. Jakes, 'The Contribution of Metaphor and Metonymy to Delusions', *Psychology and Psychotherapy: Theory, Research and Practice*, 77 (2004), 1–17 (p. 15).

28. Wm. Julius Mickle, *General Paralysis of the Insane*, 2nd edn (London: Lewis, 1886), p. 132.

29. Allan Ingram came to a similar conclusion, drawing on two case studies: one patient complained of violent pain in his stomach 'which arose from his navel string at his birth have been tied too short'; and a woman insisted that her insides were full of vermin and that it often felt as though 'they were crawling into her throat'. Ingram observes that

LONG ISLAND UNIV, CW POST COLL, ISSN:0010-5716 UNITED STATES

both had generated an image that 'genuinely encapsulates the nature of their experience' (pp. 110–11).

30. These metaphors were remarkably similar to those found in delusions of tabetic patients: see Daudet.

31. *Daily Telegraph*, 14 March 1891, p. 5. Cited by Toril Moi, *Henrik Ibsen and the Birth of Modernism: Art, Theater, Philosophy* (Oxford: Oxford University Press, 2006), pp. 92–93.

32. Susan Sontag, *Illness as Metaphor and AIDS and its Metaphors* (London: Penguin, 1991), p. 132.

33. Judith R. Walkowitz, *Prostitution and Victorian Society: Women, Class and the State* (Cambridge: Cambridge University Press, 1982), p. 53.

34. Cited by Walkowitz, p. 53; Louis Lasagna, *The VD Epidemic: How it Started, Where it's Going, and What to do about it* (Philadelphia: Temple University Press, 1975), pp. 67–68.

35. Roy Porter, *The Greatest Benefit to Mankind: A Medical History of Humanity*(New York: Norton, 1999), p. 252.

36. David E. Nye, *Electrifying America: Social Meanings of a New Technology, 1880–1940* (Cambridge: MIT Press, 1990), p. 155.

37. Tim Armstrong, *Modernism, Technology, and the Body* (Cambridge: Cambridge University Press, 1998), p. 15.

38. Carolyn Marvin, *When Old Technologies were New: Thinking about Electric Communication in the Late Nineteenth Century (Oxford: Oxford University Press, 1988)*, p. 131.

39. Graeme Gooday, *Domesticating Electricity: Technology, Uncertainty and Gender, 1880–1914* (London: Pickering & Chatto, 2008), p. 65.

Article

Introduction and the mind located in the brain

Eleonora Dophrio
USA, Illinois Univ. Department of Cultural Studies
_eleonora@gmail.com

Abstract

Where is the Mind Located?

The brain is the organ of the mind just as the lungs are the organs for respiration.

Go to:

How does the Mind Function?

Krishnamoorthy (2009) uses an analogy based on computers to explain the workings of the mind: 'The mind… is a virtual entity, one that reflects the workings of the neural networks, chemical and hormonal systems in our brain.' The mind cannot be localised to particular areas within the brain, though the entire cerebral cortex and deep grey matter form important components. Consciousness, perception, behaviour, intelligence, language, motivation, drive, the urge to excel and reasoning of the most complex kind are the product of the extensive and complex linkages between the different parts of the brain. Likewise, abnormalities attributed to the mind, such as the spectrum of disorders dealt with by psychiatrists and psychologists, are consequences of widespread abnormalities, often in the chemical processes within different parts of the brain

Keywords: mind, brain location.

LONG ISLAND UNIV, CW POST COLL, ISSN:0010-5716 UNITED STATES

The 2015 agreement, which included a Japanese promise to pay into a fund to support surviving former 'comfort women', was hailed by some as an important step towards reconciliation. But the rather vague statements made by the two foreign ministers in December 2015 left huge questions unanswered. It was unclear whether the Japanese government was even acknowledging the fact that 'comfort women' had been forcibly recruited, and subsequent statements by Foreign Ministry officials only served to further deepen the doubt (Morris-Suzuki). Rumours soon began to circulate that a precondition for the payments from the Japanese government was the removal of the 'comfort woman' statue outside the Japanese embassy: hence the presence of the young protestors, who mounted a non-stop 'guard' to prevent the disappearance of the statue (Kirk; Straits Times). What had started out looking like an act of reconciliation was by now starting to look—to some at least—more like an offer of hush-money, a payment for the creation of amnesia.

These stories highlight the profound dilemmas confronted in this special issue: conflicts over the memories and tangible scars left by wars, invasions and colonialism are a worldwide problem. Raising the spectre of international comparisons in the context of this history of violence may risk unleashing an ugly game of competitive self-justification: 'look, they are worse than us; we are not as bad as them'. But that is not, and must never be, the point. The point is that the wars and colonial violence of the nineteenth and twentieth centuries have left legacies of that injustice and violence which live on in many parts of the world. The task for those who try to address those legacies in diverse places is to learn from one another about ways to nurture redress and healing. He then dressed it with 'the Spray,' then put on chloride of zinc & moved the arm to & fro. The pain was indescribable. I never felt such excruciating pain before but often afterwards. I also felt the arm quite loose from my body […]. Prof. then said to the students, '[…] I have a great fear of putrefaction setting in here & you all know the outcome. Thus I will look anxiously for the second day, or third day, between hope and fear. I hope the chloride of zinc will preserve it, but it is only an experiment'.I

Margaret Mathewson, twenty-eight-year-old daughter of a schoolteacher in Shetland, describes her tortuous post-operative experience after undergoing surgery for a tubercular shoulder joint performed by the well-known surgeon, Professor Joseph Lister. Her narrative account of her experience in the Infirmary vividly details what it was like to be a surgical patient in Scotland in the year 1877. Mathewson not only describes what her pain felt like, but the ardent evangelical faith that helped her endure that pain. In addition, in one startling section of the narrative she describes what she believes to be a medical student's deliberate infliction of unnecessary pain, and her own and Lister's responses to this. Her account of a nineteenth-century charity hospital patient's experience, written in her own words, not

only provides invaluable insights into the Victorian hospital world 'from below', but ultimately projects a dramatic contrast to the Foucauldian image of the patient as objectified, silenced, and subordinated.2

Yet in the above quotation, Lister appears to treat his patient as an object lesson for his medical students, freely announcing in front of the patient his fear that this particular 'experiment' might not work, and that if it did not, they all knew 'the outcome'. Indeed, Mathewson responded to Lister's words with a lengthy meditation on her 'hopes of eternity', as the 'Prof.' evidently had 'very poor hopes of my recovery' (S2, 46). Mathewson's description of this episode in her hospital history seems to amply confirm Michel Foucault's thesis in *The Birth of the Clinic* (1963) that hospital patients in the nineteenth century were objectified:

> in the clinic [...] one is dealing with diseases that happen to be afflicting this or that patient: what is present is the disease itself [...]. The patient is the accident of his disease, the transitory object that it happens to have seized upon.3

The sociologist Nicholas D. Jewson even more forcefully asserts this objectification of the nineteenth-century hospital patient in his now classic essay, 'The Disappearance of the Sick-Man from Medical Cosmology, 1770–1870'. In it, he claims 'Hospital Medicine' is that in which the 'sick-man' is 'unequivocally subordinated to the medical investigator', and 'designated a passive and uncritical role in the consultative relationship, his main function being to endure and to wait'.4 On these two foundational statements of the objectification, silencing, and subordination of the nineteenth-century hospital patient, other historians have elaborated further arguments that 'the patient's view' could not be directly accessed. David Armstrong, in 'The Patient's View', suggests that the patient's view is simply a 'precise technique' demanded by medical authority. The patient's pain, once the archetypal symptom, was assumed to be accessible to the doctor only through self-reflection on the doctor's own experience of pain. 'The patient's view and the doctor's view were shadows of each other.'5 Mary Fissell, in *Patients, Power, and the Poor in Eighteenth-Century Bristol*, documents the disappearance of the patient's language and individual interpretation of his or her medical history in the case-histories of the early nineteenth century as doctors increasingly employed medical jargon written for the benefit of colleagues. In Fissell's summary, 'patients were deskilled, denied interpretive authority', and 'their bodies made to speak for them'.6 But all such critical approaches to patient history, as Roy Porter charges, 'often end up by silently reinforcing that old stereotype of the sick, i.e. their basic invisibility.'7

This theoretical perspective on hospital patients in the nineteenth century has promoted the assumption that they did not speak or write about their experience for themselves. This may be why Mathewson's account has received relatively little atten-

tion, even though it has been known since the 1970s. Her 'Sketch' was first briefly described by W. B. Howie and S. A. B. Black in two articles published in medical journals.8 Martin Goldman, a science producer for BBC Radio Scotland, then put together a book, *Lister Ward*, which included excerpts from Mathewson's 'Sketch' and some of her letters, along with poems and letters by William Ernest Henley, who had been a private patient of Lister's in the Edinburgh Royal Infirmary earlier in the 1870s. Although Goldman opens his book with the statement that 'this book is about what it was like to be a patient in a Victorian hospital, the Edinburgh Royal Infirmary, at the time when Joseph Lister was pioneering the use of antiseptics', signaling his interest in representing the patient's view rather than the conventional 'mellow haze of hero worship' in writings about Lister, he also sees the two individual stories of Henley and Mathewson as reflecting 'the universal experience of countless Victorian patients'.9 He does not regard the differences in their treatment as private, paying patient versus non-paying, charity patient as particularly significant. In his reading, both patients' accounts are 'biased': Henley's weakness is 'insincerity', or 'verses written for calculated effect rather than stating genuine feelings and responses to events'; while Mathewson's 'Sketch' is 'an evangelical tract [...] meant to convert people to hospitals and her brand of Methodism' that employs 'planted phrases' and 'planted sentiments' (Goldman, p. 147).

[3]

Still more recently Guenter B. Risse, in his history of hospitals as rooted in patient experience, *Mending Bodies, Saving Souls: A History of Hospitals*, discusses Mathewson's 'Sketch' at considerable length as his only example of a nineteenth-century account of hospital experience that is an actual 'eye-witness' account.10 However, he paraphrases most of the material he takes from Mathewson's account, thus presenting it largely from his perspective, not hers. In effect he repeats the process of silencing the patient by using his words, not those of the patient, to write her case-history as a medical historian understands it.11

Despite these acknowledgments of the existence of Mathewson's 'Sketch' of her eight months as a patient in the Royal Infirmary of Edinburgh in 1877, the unique significance of the narrative as a nineteenth-century charity hospital patient's account *in her own words* does not seem to have been recognized. The 'Sketch' has never been published in its entirety, nor has it been known that the two copies of the 'Sketch' held by the Shetland Museum and Archives differ extensively. The first, a photocopy of a complete holograph manuscript now in private ownership, is dated 8 August 1879.12 The second copy of the 'Sketch', a manuscript now held by the Shetland Archives, has only the first six pages in Mathewson's hand. The rest is a copy known to have been made by a friend of hers, Laurence Williamson. This copy is dated 27 September 1879, and in its 'Preface' Mathewson notes that 'in complying with the request of my friends to publish it I have written several copies having left out

some insignificant items and put in others more interesting' (S1, 2). My comparison of the texts of these two versions of the 'Sketch' indicates that much of what Mathewson considered 'insignificant' in the earlier copy is highly significant for Foucauldian/Jewsonian readers, for it produces an image of a Victorian-era charity hospital patient strikingly different from the passive, silenced 'body' we have been trained to expect.

By contrast, the excerpts published in *Lister Ward*, which are taken from the later manuscript, appear to invite a Foucauldian reading of Mathewson. Historian Hilary Marland, for example, comments that Mathewson 'seems to have no expectation of any power', and that this might be because she 'wishes to present a picture of Christian submission to her sufferings or, as Foucault and Jewson suggest, that she sees herself participating in a sort of unwritten contract' (Marland, p. 56). And indeed, Mathewson discovers on her first admission to the hospital that her position is that of an 'interesting case', a body on which the Professor lectures and medical students feel free to 'take lessons', a body over whose diagnosis and treatment she has no say. At one point in her narrative, she reminds herself that tho' its so far prison like, still it is not that, it is an Hospital, and tho' bleak and dreary looking I was there under the wise dispensation of God, and he will do with me just as he sees best. (S1, 26)

But a reading of both versions of the 'Sketch' in their entirety, and a careful consideration of the changes made in the later version, prompts a radical revision of Foucault's and Jewson's views on the objectification and powerlessness of the nineteenth-century hospital patient. I will quote Mathewson not only on what kinds of pain she endured, and how the staff responded to it, but how, in one extraordinary instance, she denounced what she believed to be deliberately 'cruel' treatment — only to tone down her description of the entire incident in the later version of the manuscript. Both versions of the 'Sketch', despite their numerous differences, produce a narrative of a hospital patient's progress from 'interesting' case to 'successful' and even 'favorite' case, a movement from one who is operated on to one who proudly describes to a doctor how she operated on herself, inserting a drainage tube in her own shoulder 'before a glass' (S1, 182; S2, 92). Finally when the two versions of the 'Sketch' are supplemented by some of the numerous letters written by Margaret and other members of her family, we discover important material about her methods of coping with pain even before she decided to seek admission to the Royal Infirmary of Edinburgh, as well as during her eight-month hospital stay.

'What's the best Professor's name for surgery?'

This is the question Mathewson boldly puts to the porter at the Edinburgh Royal Infirmary. It illustrates both her relative

ignorance of surgical developments at this time and her active role in acquiring that knowledge and obtaining the best medical treatment available. It is particularly appropriate that her introduction to the Infirmary should begin, not with a question put to her by a member of the medical establishment, but with her own question, demonstrating her determination to find the best possible member of that establishment for the treatment of her advanced and painful disease.

But who was Margaret Mathewson? Born in the schoolhouse in East Yell, Shetland on 18 April 1848, she was the eleventh child of a schoolteacher, Andrew Dishington Mathewson (1799–1887), and his wife, Barbara Robertson Mathewson (1807–1873). She grew up in that schoolhouse, helping with the farm-work as well as housework. She was educated solely by her father. She worked for various periods of time as a domestic in Edinburgh and Liverpool during the mid-1870s, but apparently returned home when she first developed 'chest disease' and then later pain and swelling in her shoulder.13 Before deciding to seek treatment at the Royal Infirmary of Edinburgh, she had been treated only by the local minister, James Barclay, as there were no doctors in Yell at this time. Barclay had learned what medical knowledge and skills he had from observing his father, who had been a doctor. But eventually Mathewson had decided she must travel to Edinburgh, as her arm kept getting worse, and she feared 'likely the disease was at the bone owing to the severe pain I always had in it' (SI, 1). She had arrived in Leith, the port of Edinburgh, where she had her 'usual boarding when South' two days previously after a lengthy voyage from Shetland (SI, 2). She had walked from the Edinburgh train station to the Infirmary, as she would meticulously document in the 'Sketch' she was to write two years later, on 'Fri morning Feb 23rd 10:30 AM', accompanied by Cousin Martha, or Mrs McTernan (SI, 2). Mathewson, like most of those who entered the Infirmary, was not a pauper. The *Medical Register* for the Royal Infirmary of Edinburgh in 1877 has a separate column for 'Paupers', but on the day of Mathewson's admission only two paupers were admitted: one a 'Labourer' and the other a 'Water Officer'. Occupations were listed for the other forty-eight patients, although the occupation given for female patients was usually that of the husband or father, such as 'schoolteacher' in Mathewson's case.14 They were nonetheless charity patients, treated and cared for without charge. Mathewson knew she had to have a letter of introduction in order to be considered for admission.

Though not a pauper, Mathewson clearly believed herself to be of much lower 'station' than the doctors. On the day she was admitted, she was first seen by William Watson Cheyne, who was Lister's house surgeon at the time, but later became almost as famous as Lister. She immediately recognized him as a 'Shetland gentleman', but he did not recognize her. However, after reading the introductory note from the minister Mr Barclay, the doctor seemed to recognize the minister's handwriting. 'He

then looked at me, then read the note & again looked at me, and said Do you know me? Yes Sir. Who am I? Dr Cheyne of Fetlar Shetland Sir. Yes the same (Martha was surprised we were any ways acquaint [*sic*])' (SI, 3). Mathewson was obviously much pleased by the doctor's recognition, even if belated, and tickled by her cousin Martha's surprise that she was in any way 'acquaint' with him.15 Cheyne did a preliminary examination of her shoulder and told her that it was not dislocated, but that she had an abscess in the joint and another on the collar-bone. He instructed her only to put on her outside jacket, as Prof. Lister would be in a hurry when he examined her.

When she first glimpsed Lister, passing him on his way into the operating theatre, she described him as 'an elderly looking gentleman' (SI, 4). After a rather disturbing interval during which she and Martha heard 'fearful screams' and then saw first a man carried out in a basket followed by his leg wrapped in silk paper, 'the blood tipping from it', she was introduced to Lister by Cheyne. Cheyne now called her 'an acquaintance of his from Shetland' (SI, 7). Mathewson comments in her 'Sketch' that Lister 'seemed to be a kind and good man' (SI, 7). Lister then examined Mathewson's shoulder again, enquiring into how long ago the trouble with the shoulder joint had begun. She answered, '12 months, Sir' (SI, 7). He also asked how the 'opening between the joints' had been made, and she answered that the Rev. Mr Barclay had made it a month ago. 'How did a minister make the operation?' Lister asked, and she replied that Mr Barclay was all the Practitioner there was in 'our island', a point confirmed by Cheyne (SI, 8).

What Mathewson did not tell Lister, however, was that in the absence of a 'Practitioner', and after Barclay's operation had been only partially successful, she had opened the joint herself. In an eight-page letter to her older brother Arthur dated 31 January 1877, she describes what had happened:

Now about my arm. Well I told you it was gathering & it continued to do so but was not like to burst (or even get Yellow & never did) thus I went to Mr Barclay on New Years day & he told me to call at Thos. Johnson's Reafirth & get a little Linseed meal for Poultices & use it till Wednesday following when he would call here. I did so but found the Poultices setting it backward. But Mr B came on Wednesday & opened it he got a lot of matter out then mixture. He also said the Poultices was set it back. The 3rd day after it gathered again & I opened it myself & got as much stuff again & I then made flour poultices & kept it open & a third time it gathered & I am still going on with poultices (now bread or loaf) & its issuing a very little yet & I find my shoulder is dislocated.16

Clearly, Mathewson had acted as her own surgeon when she felt that the minister's efforts were unsuccessful and even misguided. She not only opens the abscess — a process that must have been extremely

LONG ISLAND UNIV, CW POST COLL, ISSN:0010-5716 UNITED STATES

painful but on which she does not enlarge — but she decides to use 'flour' poultices apparently made from bread. She does not, however, inform Lister about her surgical self-treatment.

Lister also asked her whether she had ever fallen on the shoulder (she had, in a hay loft), and what the marks on her chest were. They were marks from 'a drawing plaister', she replied, and when he asked what that had been for, she replied, 'for chest disease Sir' (SI, 8). Lister then, Mathewson wrote, 'sat down folded his hands closed his eyes as if in silent prayer (which gave me more confidence in his skill and I also lifted my heart in prayer of thankfulness to God for directing me to this Christian gentleman)' (SI, 8). After this, he took a silver probe out of a case in his pocket. It was about four inches long, and he pushed it into her shoulder joint so that she could feel it 'quite into the shoulder cup' (SI, 8). The probing felt 'very sore' and made the shoulder bleed a little. Lister then asked her how long she had had 'chest disease', and she said, 'for about three years Sir' (SI, 9).

During the examination, Lister then turned to the students and said, Now gentlemen this quite accounts for the shoulder being diseased. The patient has had chest disease, and has suffered a great deal from it but now instead of falling deeper into the lung, it has very providentally [*sic*] turned off from the lungs into the shoulder joint had not this operation been made in the arm — it evidently would have returned to the lungs, and the patient would have died immediately. But this operation has drawn off a lot of discharge. (SI, 9)

In the earlier version of her 'Sketch', Mathewson includes in parentheses, 'this was just a repetition of Mr Barclays words when he made the operation' (SI, 9). In the later version, she omits this rather devastating comparison of the famous professor's medical opinion to the obscure minister's.

Following this examination and history-taking, Mathewson reports that Lister said, 'Well we will sound your chest some day and see what we can do for you' (SI, 9–10). This meant that she was to be admitted. Lister had decided that he might be able to help her by operating on her shoulder, as the disease had 'providentially' turned from the lungs into the shoulder joint. That tuberculosis was a systemic disease caused by a specific bacterium was not even imagined by doctors at this time (Robert Koch did not identify the tubercle bacillus until 1882). Lister's notion of 'germ theory' was still only partially based on Louis Pasteur's new theory of airborne microorganisms, despite his use of 'antisepsis' intended to destroy bacteria entering the body from the exterior and thus causing wound 'putrefaction'.17 But his admitting examination and questioning of the patient was as complete as his germ theory was incomplete: he tried to elicit full information from Mathewson about her medical history, her medical treatment so far, and her own opinion about her illness.18 That she did not tell him everything, and that his case notes — had he written any — would have differed from this patient's view, not only of her own case but of her surgeon's

degree of expertise, he was, of course, unaware.19

'What like is your pain?'

On her first night in the hospital, Mathewson did not have much opportunity to see how well she could sleep in this 'strange scenery' with the pain in her arm, as she was awakened by the commotion of a railway accident patient being brought in (SI, 19). But on the second night, she fell asleep earlier than usual, only to wake at around 11:40 p.m. At about midnight, she noted, Cheyne came in and checked on each patient as they slept. When he found Mathewson awake, he questioned 'Dear-o-me! How are you awake at this hour alone?'. When she explained that she had just woken up, the doctor asked 'Have you pain in your arm?' and 'what like is it?'. But when Mathewson replied that her pain 'wakens me out of sleep', and feels 'as if the arm was starting off', the doctor only replies, 'Yes so it is. O well I hope if you stay long with us you will get free of all your pain and good night' (SI, 19–20).

Pain medication was apparently not given preoperatively in any form in Lister's wards. Mathewson had to wait a full month in the hospital before her operation, probably because her arm continued to suppurate. Although she was allowed to walk about the ward freely, and to observe and talk to other patients, she does not describe any sort of pain medication being administered to herself or to other preoperative patients.20 Morphine was available in both oral and injectable form at this time, but Mathewson and patients in Lister's wards do not seem to have even been aware of its existence, or of any other pain-relieving agent except chloroform — and that was used only for major surgery. This was in contrast to other hospitals of the time: S. Weir Mitchell's work indicates that morphine was used freely to relieve the pain of war wounds in American hospitals.21 It was also in contrast to the apparently common use of opium in Britain to relieve the pain of those ill or dying with such diseases as tuberculosis at home.22

Mathewson describes, for example, the pain she observed in a woman with a twisted elbow joint whose hand has been 'put on the extension', which Mathewson carefully explains involves having increasing weights of sand attached to it by a cord and hung over the foot of the bed. After the weight of the sand has reached twenty-one pounds, the woman's hand and arm turn blue. Mathewson asks her if she feels much pain. The woman replies, 'Oh the pain is very bad', and asks if Mathewson can tell her why she is treated thus (SI, 44). Mathewson explains that the treatment is intended to 'stop the lower part of the arm from grating on the top part and to keep it in a proper position' until the operation can be performed (SI, 44). Yet the patient is not offered any medication, or Mathewson does not mention it.

Mathewson appeared not to regard pain as something she or anyone else was divinely ordained to suffer. As a convert to Wesleyan Methodism, she took very seri-

ously her obligation to teach others about Jesus's ever available forgiveness and love, as well as to do anything she could to help them bear their pain. But she never spoke about pain as punishment imposed by a just but vengeful God, or as a special mission to bear Christ-like suffering. For the woman whose arm had been put 'on extension', and who turned out to be a 'Catholic' (Roman Catholic), Mathewson first explained to her that the reason she did not feel any better even the second day after the operation was likely due to the effects of the chloroform, which would stay with her for some time after she had got over the operation, but then continued, 'I hope if you do not get better you will get home to heaven where theres no more pain' (SI, 46). When the woman exclaimed, 'Oh yes, Father will plead for me!', Mathewson insisted that she did not need Father O'Reilly; she did not need any priest except Jesus; that Jesus had suffered 'fearful pain' to prepare a place in heaven not only for the disciples but for 'every person as well which would believe he had suffered their punishment instead of them before God' (SI, 50–51).

Mathewson also stated that she did not believe in the doctrine of 'Election', at least not to the extent of believing that God '"elected" or ordained some to everlasting life, and some to everlasting death' (SI, 146). In Calvinist Scotland, many believed that pain and suffering in this life was an indication that they were doomed to everlasting pain and suffering in the next life. Mathewson's evangelical faith clearly led her to reject any idea that a profoundly loving and compassionate God could condemn human beings to everlasting punishment, and this belief also allowed her to feel that she could and should do anything possible to relieve her own pain and that of others — not only the mental torment of believing that one's pain was the consequence of guilt and sin, but the physical pain of the body as well. As she explained to a young doctor, she had never 'joined the teetotalism', thus she did not reject the use of alcohol, which happened to be about the only form of pain relief that was available on Lister's wards (SI, 189).

In a note written in pencil on 28 March, five days after the surgery, addressed to her brother Andrew and his wife Jane, Mathewson writes that the Professor had

moved the arm back & fore & up & down oh how sore it was I almost fainted so last night it was so painful I slept very little & am most have fainted 2 or 3 times as I was so weak I didn't know where at all I was & after a bit I ast the nurse for a teaspoon of brandy, but she was in bad temper after a little I ast a drink of water but no I got none until her time came the night nurses is the worst ones.23

It would appear that some nurses, but not all, were averse to providing patients with brandy. In a letter dated 12 April, almost three weeks after the surgery, Mathewson wrote in a letter to 'Dear Father Brother & Sister, etc.' that

Yesterday & last night I took bowel cramp, & was very ill but got little sympathy from those queer nurses & the head nurse Miss Logan was in another ward on duty there & none of this ones would give

me a teaspoon of brandy or make me a cup of tea but laughed at me & by chance Miss Logan came & I ast her myself for a little brandy & told her for why. She went & gave me near a glass of brandy, which eased me instantly.24

After surgery, however, doctors appear to have routinely administered morphine orally to patients. Mathewson, like at least one other patient whom she describes, tried to refuse the morphine, apparently believing it was an emetic or purgative.

Nurse kept feeding me with 'Ice' & asked if I felt much pain. Yes nurse a good deal. Would you please give me a little lemonade as I feel so hot. She brought it & sat down taking my pulse every ¼ an hour. As the night wore on the pain increased. I asked nurse for another pillow hoping I would not feel so giddy but it was all the same & feverishness increased & nurse observed me — restless & asked will you have a drink. Yes please nurse? she went for it was such a time away but was upstairs (as I supposed getting a draught from the Dr, came back with a medicine glass of murphey etc which I was resolved not to take but after some persuasion did take. Dr Cheyne came in about 12 p.m. and said well nurse how is the patients? Margt is very feverish & restless owing to a lot of pain [...] did Margt take the medicine? Yes Sir after some persuasion. How was that? Well, I believe she thought it was other medicine but as soon as she heard it was really for the pain she took it at once. Oh I thought she had a good reason for saying 'no,' but seeing she has taken this I can't give more at present. But give her plenty of 'Ice' mind Yes Sir. (S1, 70–71)

[8]

In the later version of the manuscript, Mathewson gives the correct name to the medicine, but seems to also feel she has to explain in greater detail her initial resistance to taking it:

As the night wore on, the pain increased, also the feverishness, and at times I was on the eve of shouting, the pain was so severe. I then thought 'I shall not shout as long as I can avoid it.' I thus hid my mouth in the sheet. I felt giddy and asked nurse for another pillow, and got it as I fancied I would not feel so sick. But it was the same. I felt so warm, I put down the quilt. Nurse said 'No you must not put off the quilt, but keep chewing ice and that will keep you cool, but would you have a drink.' 'Yes nurse please.'I thought now I would get a jug of cold water and I knew if I got hold of it I should take a drink. Nurse [...] then returned with a medicine glass of morphia, laudanum etc. She told me to take this quite up, and it would better me. I was not inclined to take it at all, as I had seen the effects of similar drafts on others that I was determined not to taste it if ever it came to me. She persuaded me, and told me 'It would ease the pain which you are trying to choke every now and then.' I took it quite out, when I heard it would ease the pain. (S2, 42–43)

When the doctor checks her, Mathewson's account in the later version has the

doctor testifying to her willingness as a patient to do anything she was asked:

About 12 P.m. the doctor came in and said 'How are the patients?' 'Margaret is very feverish & restless and has a lot of pain […]' 'Did she take the medicine?' 'Yes as soon as she heard it was for the pain, but ere then I thought she would not take a drop.' 'Dear-o-me how was that as I thought she was nowise averse to anything we have wished her to do before at least? I have always found her so haven't you?' 'Yes I must say so too but I believe she thought it was some other kind of medicine as she told me she did not require it.' 'Oh, I thought she had a good reason for saying 'no.' Well, seeing she has taken it I can't give more at present, but give her plenty of Ice mind.' 'Yes sir.' (S2, 42–43)

Mathewson also describes the 'Catholic' patient as being unwilling to take the medicine offered her after surgery:

She continued very weak during the evening and seemed to get worse as the evening wore on. Dr Cheyne (our house Dr) came & took her pulse every half hour, and a special nurse was set at her bedside. Dr Cheyne came with a medicine glass full of morphia etc. and offered to her. She was very against taking it. He pressed on her to take it, and it would make her better. She did so after some persuasion.25

The day after the surgery, Lister came into the ward with a 'train of students' and asked whether she felt any pain. When she said she did, he asked 'What like is it? [*sic*] Is it an aching pain, or a severe pain, or starting pain? It is a squeezing pain Sir as if squeezing by a cord' (S1, 73). In the later manuscript, she enlarges on this questioning of the specific nature of her pain: '"What like is it? Is it a severe pain, an acute pain, an aching pain, or starting pain?" "It is neither sir. It is a squeezing pain, as if it was squeezed between two things or articles or with a cord, sir"' (S2, 42). In both versions of the 'Sketch', Lister accepts the patient's description of her pain as if it confirms his expectations, but he also supplies descriptors of pain, as if using the patient's pain experience as a diagnostic aid. In Mathewson's later version of the exchange, she gives herself the credit for coming up with the exact descriptor — 'squeezing' — as if she had more fully realized how important the precise character of the patient's pain was to the physician's diagnosis.

Then follows the first dressing change, during which Lister puts the arm through the full range of motions, causing the 'indescribable' and 'excruciating' pain as described in the opening quotation for this essay.26 In the later version of the 'Sketch', the dressing is followed by Lister using the opportunity to teach the students more about pain:

Prof. said to the students, 'Gentlemen the patient said to the Dr this morning on being asked if she had any pain, she said "I feel it sore but not painful." Now gentlemen, can you tell me what she meant?' 'She means that she wants a name for the pain Sir.' 'No she expressed herself exactly as she felt it at the time, and I am glad she did as it brings out a something I have been wishing to hear from some patient or another for some time back. Her expression is a

Scotch phrase. An English person would have said quite the opposite — painful but not sore, but although I am an Englishman, I quite understand her. Have you not observed during the dressing how she tried to hide the pain by putting the sheet in her mouth? It shows me that she suffers a great deal more of pain than she wishes to let us know about and that is characteristic of Scotch people. An English person would infer that she feels a great deal of less pain than she would wish to let us think she did, but she really does not. However, I have a great fear of putrefaction setting in. (S2, 45–46)

The rest of the paragraph follows as in the opening quotation. Here, Lister interprets her description of her pain as an indication of her national character: like 'Scotch' people in general, she is stoic and wishes not to let others know how much pain she suffers. It seems clear from Mathewson's description that she took considerable pride in his evident admiration for her stoic 'Scotch' courage. But her stoicism had its limits, as was soon to be demonstrated by her encounter with the 'cruel dresser'.

'I am determined to inform on you'

Soon after this episode, Lister (and Cheyne) left for London. Mathewson was left to the care of the new House Surgeon, Dr Roxburgh, whom she describes as being 'very kind to me' (S1, 107). But then there was a change of dressers (medical students who bound wounds), as every six months students were rotated for duty in the surgical or medical wards. Mathewson was then assigned to one of the new student dressers, a fateful change for her. 'Until then,' she wrote, 'I had not known experimentally what a "cruel dresser" meant' (S1, 107):

The first dressing Mr __ made I really thought he had overturned all the ligaments etc. which had then begun to go together. the pain was dreadful and the draw sheet & pillows etc had to be changed for the blood from the wound then the bandages was tight. Miss Logan came in and I was leaning on the table & crying from the pain & soreness. Dear-o-me have you got bad news. No Miss Logan, not in the way you mean, but I have got a cruel dresser!! (S1, 107–08)

She slept but little for the following two nights, and this was the case every time Mr __ (she never names him in either version of the 'Sketch') changed her dressings for the next three months.27 A letter to Mathewson's father dated 11 June 1877 demonstrates that, if anything, her description of the cruelty of this dresser is understated in the 'Sketch':

I mean to ask <thro the week> if they will let me go to the convalescent now, as then I would (I hope) get free of the fearful Squeezing Mr Hart gives me arm It couldn't be worse any way I think if it should'nt be much better. On Saturday he dressed me sitting on a chair (as I was up before he came, just to see if it would be any better being out of the bed) & it was worse than ever but I tried not to cry out much, he put his knee on my side below my

arm and pulled up my arm with both hands the blood ran down over my clothes (thro the places where the tubes was in) it was very sore and painful all Saturday afternoon & night & I hardly sleep't any & it was still sore Yesterday morning but got a little better after that so as I sleept very well last night.28

At last, the dresser went on holiday to 'Vienna', and while he was away, Roxburgh again took over the dressing changes, for which she was 'thankful' (SI, 109).

But when Mr __ returned from his holidays, the torture of dressing days began again. She told herself that Mr __ was 'trying experiments' on her case and didn't really have a 'cruel design' (SI, 109). But then one day he asked her if she was not 'wearying to get away', and she replied

I am indeed. But your style of dressing is preventing my progress and prolonging my stay here. Well you know yours is a rare case and that's my chance for lessons," [*sic*] Well Sir Indeed, if you presume to dress me any longer so cruel, I am determined to inform on you, as I have that privilege if I choose, thus I am reminding you of that, so as to prepare you for your dismissal, Sir Do you really mean it Margt? I really mean what I say sir, as I have suffered too long for your pleasure & rather than to cause any gentleman lose so important a situation as you are preparing to fill. Well I am much obliged to you for this notice as I know you have it in your power to cause my dismissal, & I beg your pardon, & I shall not be so hard again If you don't inform this time yet. (SI, 109–10)

However, there was no difference in the way the student did her dressings thereafter, and when Lister returned from London to visit his patients in Edinburgh again, he was shocked by the condition of Mathewson's wound:

He came and began to undo the bandages on my arm when he came to the sore he stoped & asked whats been doing here (?) Who is the dresser? Mr __ Sir said Dr Rgh Well Mr __ you have not failed to move the joint here (Mr __'s face got red) and have reopened what was set together Sir which Im sorry for as I expected to see its great progression at this date. Then the pain it must have given the patient! (SI, 110)

Lister's reputation for rebuking students severely if he thought they had mistreated a patient is well known. M. Anne Crowther and Marguerite W. Dupree comment that 'his pained and public reproaches if dressers appeared at all careless or treated patients without proper consideration affected his supporters for the rest of their careers' (p. 102). Here Mathewson goes on to report the following conversation with Lister:

Dr did she never report Mr __ to you? 'Never to me Sir then said to me Did you always feel pain after the dressing? Yes Sir And did you always sleep well the following nights No Sir, I seldom slep't any the following two or three nights Sir. Just so, well do you think Mr __ did it from cruelty, or to cause you pain? No Sir, I think Mr __ did it so as I should not have a stiff joint afterwards, Sir. How do you think so? I think so Sir, as Mr __ told me I would be

able to pull him around the bay near our place in Shetland, when he came there to spend his holiday yet someday perhaps Sir (a laugh.) very good proof, gentlemen, the patient understands the term 'a stiff joint.' Now Mr __ you see this young woman has not said a word against you to any person & surely you will treat her more gentle. (but no it was the same next dressing day.) (S1, 110–11)

Lister's question as to whether Mathewson had ever reported Mr __ suggests that, if she had, the student would have been dismissed from the cherished post of dresser, just as she has stated in her account of her confrontation with the student. Even more significantly, this account suggests that Lister believes the student might have been deliberately sadistic, manipulating her arm as he did in order to cause her pain, just as Mathewson implies in her accusation that she is suffering for his 'pleasure'. Certainly both medical students and practitioners have been accused of sadism throughout medical history, but that charity patients would be encouraged to report a sadistic dresser and that this might result in the dresser being dismissed is a development unexpected at this point in nineteenth-century hospital history.29

Mathewson's version of the 'cruel dresser' story is significantly different in the manuscript dated 29 September 1879, however. It appears to have been carefully edited not only to improve the writing stylistically but to represent Mathewson's behaviour as literally more 'cautious'. She describes both her new dresser's treatment and her response to it in more succinct and less graphic terms:

There was a Mr __ who got all the cases in No 2 to dress, but until then I had not known what a 'cruel dresser' meant as my sufferings only began then. The first dressing I believed he had again drawn my arm out of the cup & reopened all the wounds etc. The two following nights I slept none at all, & this was invariably the case after dressing me while he was on duty. I felt sure I could not progress under his treatment, and consequently would have to stay a long time still in the Infirmary. (S2, 63)

Her leaning over the bed sobbing, and crying out to Miss Logan 'I have got a cruel dresser!' is not mentioned at all, and the description of the blood running down all over the bed such that the linen required to be changed has been omitted.

When Lister returns from London and asks her how she is getting on, she replies, 'Thank you Sir, but ordinary.' When he responds, 'How is that? You ought to be getting on well by this time', she comments,

I did not answer Professor's question, as I did not wish to inform on Mr __ as there were a great amount of events might come out of it. I was not aware of at the time, and evidently it could only add to my suffering instead of abating it. Thus I avoided giving the information for a time hoping Mr H. would improve. (S2, 63)

When the Professor undoes the bandage, however, he immediately asks 'Dr

what's been doing here? Who is now the dresser of this case?'. When told that it's 'Mr H. sir', Mathewson comments, in parentheses, that '(Mr H. was present & took a red face.)', adding the following dialogue between Lister, Mr H., and the other medical students and doctors accompanying him on hospital rounds:

'Well, Mr H. you have not failed to move the joint, but this is too much and has reopened what was now set together, and thus retarded the healing process. And then the pain it must have given the patient. Did she ever report you to Dr Roxburgh?' Dr Roxburgh said 'Never to me, Sir.' Prof. then asked me 'Did you always feel pain after the dressing?' 'Yes Sir.' 'And did you always sleep well the following night?' 'No Sir, for the two following nights I seldom slept any.' 'Do you think Mr H. did it intentionally to cause pain?' 'No Sir, I think Mr H. did it chiefly so as to secure good movement of the joint, so as I should not have a stiff joint. Prof. then patted me on the back, and said, 'You are a considerate and patient young woman.' 'Now Mr H. you see she has not said a word against you, therefore you will surely treat her more kindly.' 'Yes, Sir.' 'I had to be cautious how I answered Prof. here again, as I believed a great deal would depend on what I said regarding the dressing, as 'Many a word in anger spoken, finds its passage back again' says the poet. (S2, 63–64)

In this version, Lister's question, 'Do you think Mr H. did it intentionally to cause pain?' clearly states his awareness that the dresser's motives might have been purely sadistic. But Mathewson's somewhat confusing account appears to explain her failure to report his cruelty as the fear that he might simply be even more cruel thereafter. The whole episode in the earlier 'Sketch' in which she confronts the student and threatens him with dismissal is omitted. In this later version, she makes a complaint to the dresser only after Lister has questioned the dressings and rebuked the student, and her complaint is far more circumspect:

Prof. then had to go again to London, and Mr H. dressed me again; but his manner of dressing was the same. I then told him I was determined to tell Dr Roxburgh if he did not treat me more gently in moving it. He was a little better after that. (S2, 64)

Her quotation of a line from a poem commonly included in anthologies of poetry and hymns seems designed to give the whole episode a less shocking, more literary character.30

'And what a successful case it came to be'

After a number of weeks spent in the Convalescent Home in Corstorphine and a few more recuperating at her brother Walter's home in Campbeltown, Mathewson was able to return to her home in Shetland. There, having heard that Cheyne was home on the island of Fetlar for his holiday, she went to see him. It was in her view, I believe, a triumphal visit. In her own words:

In the summer of 78 [...] I went to Fetlar to see [Dr Cheyne] for advice on my arm also to let him see its progress. He probed it to see if it was sound at the bone. I felt it in the shoulder cup, and for some

days after it was very sore. He asked if it had ever gathered Yes Sir it gathered three times after I came home.' 'What did you do?' I wrote to Dr Chiene Edinburgh and he sent me a drainage tube.' 'And who put it in?' 'Myself, sir, before a glass.' He was very much amused and surprised at this, then had lots of questions; then said, Well it is quite sound at the bone and it will doubtless get to be as strong as the other yet, and what a successful case it came to be and I am so glad to see it'. (S2, 92)

Mathewson added, in this later version of her 'Sketch':

It healed quite up in August and since feels much stronger. It was 17 months healing. Now I can do any sort of indoor work, even washing clothes, etc. And looking back through this ordeal of trouble, how I am laid to wonder, and adore God's love,

and she concludes with a quotation from a hymn (S2, 93). Little more than a year later, her father wrote to his remaining children, Joanna, Laurence, and others, 'I write to you at present to let you know that I followed my Dear Margaret your Sister to the Grave in the Asaylum [*sic*] in MidYell on the evening of Saturday the 2nd October'.31 In addition to Margaret, he lost two other children that single year of 1880. Arthur died at age forty-one on 20 February 1880, Walter died at age thirty-eight on 31 October 1880, the two brothers most probably, like Margaret, succumbing to tuberculosis (Goldman, pp. 144–45).

Margaret Mathewson's 'Sketch' was not published, even in excerpt form, for over a hundred years. William Ernest Henley's poems about his hospital experience as a private patient of Lister's, by contrast, were published in the *Cornhill Magazine* in July 1875 under the title: 'Hospital Outlines: Sketches and Portraits'.32 His hagiographic poem on Lister, here titled 'A Surgeon', later titled 'The Chief', has been quoted repeatedly in medical journals and elsewhere.33 One could certainly speculate that, in titling the account of her experiences in the Edinburgh Royal Infirmary a 'Sketch', Mathewson encodes her dreams of becoming not only a nurse — even a nurse-surgeon — but a writer. After all, the most popular writer of her day, Charles Dickens, had begun his career with *Sketches by Boz*, in which is included 'The Hospital Patient'.34 What would it have meant had Mathewson lived long enough to publish her 'Sketch'? How would 'hospital medicine' have been changed if Mathewson's 'Sketch' had in turn spawned a genre of hospital patient narratives, parallel to but contrasting with the 'invalid narratives' produced by more elite Victorian writers?35Mathewson's 'Sketch of Eight Months a Patient in the Royal Infirmary of Edinburgh 1877' marks a vital, and perhaps unique, moment in the history of hospital medicine, documenting treatment in one British hospital as seen 'from below'. But this patient charts her medical history as a rise from one subordinated to medical authority to one who speaks — and acts — on her own behalf. When we read this patient's account *in her own words*, we realize

LONG ISLAND UNIV, CW POST COLL, ISSN:0010-5716 UNITED STATES

that Foucault, Jewson, and others elaborated their theories in the absence of any autobiographical testimony from Victorian hospital patients themselves. While their theories have served well as foundation and ongoing support for the 'patients' rights' movement that emerged in the late twentieth century, we need to heed Porter's charge that those theories are also continuing to reinforce that old stereotype of the basic invisibility — and inaudibility — of the sick. Margaret Mathewson stuffed the sheet in her mouth so she would not 'shout' with the pain. But in writing her 'Sketch', she reversed her self-silencing, and we can hear that shout if we read what she wrote.

References:

1. Roger French and Andrew Wear (Abingdon: Routledge, 1991), pp. 92–109. I thank the Wellcome Trust for partially funding the research for this article. Margaret Mathewson, 'Sketch', partial holograph manuscript (first six pages) completed by a friend (Laurence Williamson), held in Shetland Archives, #D.7/77, 44–46. Further references to this manuscript are given in the text as 'S2'.

2. I take the phrase, 'from below', from Roy Porter, 'The Patient's View: Doing Medical History from Below', *Theory and Society*, 14 (1985), 175–98.

3. Michel Foucault, *The Birth of the Clinic: An Archaeology of Medical Knowledge*,trans. by A. M. Sheridan Smith (New York: Vintage Books, 1994), p. 59.

4.Nicholas D. Jewson, 'The Disappearance of the Sick-Man from Medical Cosmology, 1770–1870', *Sociology*, 10 (1976), 225–44 (pp. 234–35).

5. David Armstrong, 'The Patient's View', *Social Science of Medicine*, 18 (1984), 737–44 (pp. 739, 742).

6. Mary E. Fissell, *Patients, Power, and the Poor in Eighteenth-Century Bristol*(Cambridge: Cambridge University Press, 1991), p. 148.

7. 'Introduction', in *Patients and Practitioners*, ed. by Roy Porter (Cambridge: Cambridge University Press, 1985), pp. 1–22 (p. 2).

8. W. B. Howie and S. A. B. Black, 'Hospital Life a Century Ago', *British Medical Journal*, 28 August 1976, pp. 515–17; 'Sidelights on Lister: A Patient's Account of Lister's Care', *Journal of the History of Medicine & Allied Sciences,* 32 (1977), 239–51.

9. Martin Goldman, *Lister Ward* (Bristol: Hilger, 1987), p. ix. A selection of excerpts reprinted from those in this work also appears in *Health, Disease and Society in Europe, 1800–1930: A Source Book*, ed. by Deborah Brunton (Manchester: Open University, 2004), pp. 32–36; and Hilary Marland comments on it in her textbook essay for the course: 'The Changing Role of the Hospital, 1800–1900', in *Medicine Transformed: Health, Disease and Society in Europe 1800–1930*, ed. by Deborah Brunton (Manchester: Open University, 2004), pp. 31–60 (p. 56).

10. Guenter B. Risse, *Mending Bodies, Saving Souls: A History of Hospitals*(Oxford: Oxford University Press, 1999), pp. 361–87.

11. In addition, Risse seems unaware that the version of the 'Sketch' which he cites — a photocopy of the 'Sketch' then held in the Medical Archive Centre at the Edinburgh University Library — is not the same as the version reprinted in Goldman's *Lister Ward*.

12. Margaret Mathewson, 'Sketch', photocopy held in Shetland Archives, #SA.2/340. Further references to this photocopy are given in the text as 'S1'.

13. The exact dates of her work in Edinburgh and Liverpool have not been determined, but evidence from family letters indicates she may have first developed symptoms of 'chest disease' in 1873, and swelling in her armpit as early as March 1875.

14. *Medical Register*, Royal Infirmary of Edinburgh, 23 February 1877, Lothian Health Services Archives, LHB1/126/40.

15. In the later version of the 'Sketch', Mathewson changes her comment about Cheyne's recognition of her to the more socially sophisticated 'Martha was surprised we knew each other' (S2, 5).

16. Uncatalogued letter, Shetland Archives. This letter is partially quoted in Goldman, p. 20.

17. Michael Warboys proposes that although Lister based his system of wound treatment in the 1870s on Pasteur's theory of 'panspermism', he also continued to believe that much wound inflammation was chemical in origin and caused by dead or decomposing tissue in the body. See *Spreading Germs: Disease Theories and Medical Practice in Britain, 1865–1900* (Cambridge: Cambridge University Press, 2000), pp. 77–82.

18. Jonathan Gillis suggests that from 1850 on, the trend in patient history-taking moved towards seeing the patient's history as 'a superficial, chaotic story' as contrasted to the physician's 'deep, "true" history'. Lister's history-taking, as recorded by his patient Mathewson, does not quite fit this model, suggesting instead that Lister regarded the patient's story as true but almost inevitably corroborating the physician's diagnosis. See 'The History of the Patient History since 1850', *Bulletin of the History of Medicine*,80 (2006), 490–512 (p. 494).

19. Although the Royal College of Surgeons of Edinburgh Archives holds two ward case-books from the years 1869 to 1870 and 1871 to 1872 which list Joseph Lister as surgeon, Lister did not make any notes himself in these books. Notes were kept by other surgical staff members. No case-books from 1872 to 1880 are known.

20. She commented in a letter dated 6 March 1877 that 'my arm is issuing just about the same as when home and the Drs say while it keeps open they can't open the other abscess'. Uncatalogued letter, Shetland Archives.

21. Roseleyne Rey notes that S. Weir Mitchell's work indicates that there was 'no reticence at all in using morphine' to treat war wounds in the United States, as it was not until 'after the 1870s that the limitations of opiate remedies began to be questioned by the medical world which, up until then, was not aware of the problem'. See *The History of Pain*, trans. by Louise Elliott Wallace, J. A. Cadden, and S. W. Cadden (Cambridge, MA: Harvard University Press, 1995), p. 229.

According to William Dale, M. D. Lond., 'opium is our ordinary and universal catholicon during the course and specifically towards the close of the fatal maladies at which we have glanced — as cancer, phthisis, asthma, angina pectoris, etc.' See 'On Pain, and Some of the Remedies for Its Relief', *The Lancet*, 97 (1871), 739–41 (p. 740).

23. Uncatalogued letter, Shetland Archives.

24. Uncatalogued letter, Shetland Archives.

25. S2, 28–29. It is also possible that liquid morphine's bitter taste made it unappealing to postoperative patients, or that other ingredients with which it was mixed did so. But it does seem clear that neither Mathewson nor the other patient were aware that it would relieve their pain. Nor does Mathewson ever mention how effective the drug was, or speak of requesting it, as she does of brandy.

26. In the earlier 'Sketch', Mathewson's description of her pain at this first postoperative dressing is similar though a little less elaborate: 'The pain was undescribable as I had never before felt such pain and I almost fainted from it, & the sweat ran down over me like water, and I felt the arm quite loose from my body, & I felt so weak at the thought of having lost my arm after all!!' (S1, 74).

Article

Azerbaijani-English bilingualism as a fact of the modern language situation

Kamala Jafarova

Azerbaijan University of Languages, Department of the linguoculturology, Azerbaijan

Kamacafarova_adu@mail.ru

Abstract: One cannot study a foreign language without coordinating it with native language. It is necessary to arrange the process in a more effective way, so that the native language might not impede, but help to learn a foreign language. It requires examining key problems experienced by some learners in the process of studying, as well as determining the ways to overcome them.Many scientists and investigators pay a considerable attention to the problems of bilingualism, particularly, to the interfering impact of native language in learning a foreign language. Interference in linguistics is a consequence of influence of one language on the other. This is an interaction of language systems, deviations from the norm and system of non-native language takes place as a result of impact of native language. We support the idea of V.A.Vinogradov in understanding interference to be an interaction of language systems in the context of multilingualism where an uncontrolled transfer of certain structures or elements of one language to the other takes place. Such aphenomenon may appear both in the oral and written speeches.(Vinogradov, 1990, p.102).The main objective of our paper is to study the phenomenon of "interference" of native language in teaching English and discoverthe common mistakes. First of all, it requires identifying thereasons, why such mistakes take place. Languages are in close coordination when people or nations get in touch with each other. It took many historic periods for nations and their languages to be in cooperation so that the system of teaching non-native language might be established. However, regardless of such historic periods, the native language speaker had copedwith the phenomenon of interference every time he tried to

LONG ISLAND UNIV, CW POST COLL, ISSN:0010-5716 UNITED STATES

understand and learn the language of other nation – the leading function of native language as to its different nature formed obstacles in learning a foreign language.

Keywords: interference, grammatical interference, bilingualism, language interaction, source language, target language

Introduction:

The one, who learns a foreign language hardly, escapes the impact of the phenomenon of linguistic interference. Such phenomenon arises as a result of influence of one language on the other. As a rule, native language has an influence on a foreign language, but on an advanced level the situation may change. Interference may appear both in oral and written speeches, as well as in all the linguistic levels.

According to U.Weinreich, "grammatical interference occurs when the rules of arrangement, harmony, selection and modification of grammatical units involved in the system of one language are applied to similar chains of elements of the other language". The investigator offers to distinguish three types of interference in terms of grammatical relations:

- Reproduction of the relations of the other language, which expressively delivers a meaning far from that of the meaning implied by a speaker;

- Reproduction of the relations of the other language where relation model existing in the language is interrupted, as a result of which, the utterance may either lose its sense, as a whole, or its meaning becomes apparent from the context;

- Unnecessary application of certain type of relations to a language which does not require any obligatory relations in this sphere. (Weinreich, 1953, p.112)

We accept such types of interference and would like to add that one of the main reasons for grammatical interference is connected with the learners who apply the rules of arrangement of grammatical units in a sentence, harmony of parts of speech, as well as selection or compulsory modification of grammatical units inherent in native language which may seem to be similar, in their opinion, with the elements and structures of the English language. Such substitution of grammatical constructions also results with the violation of the norms of the studied language.

I. Method of Investigation

In the condition of Azerbaijani - English bilingualism, in the English speech of the students, implementation of process of interference is based upon the study of typological distinction between Azerbaijani and English languages including the diversions from the norms of oral and written speeches of Azerbaijani students. 1100 papers and 255 minutes' records of oral English speech of students on various free topics and certain grammatical features, over 990 linguistic usages were studied.

The research of the oral and written English speeches of students shows that all the known types of interference such as

introlingual and interlingual, explicit and implicit interference, direct and indirect interference occur in the students' English speech. These types can be noted in different levels of the students' English speech – phonetic, lexical-semantic and grammatical levels.

In order to carry out this research work we have used the descriptive, comparative methods by subjecting the specific language materials to analysis, implementing grammatical models of English and Azerbaijani languages.

2. Scope of Investigation

The Scope ofinvestigation covers the phenomenon of interference and the mistakes by the Azerbaijani students in learning English as a second language.

3. Grammatical Interference and its Influence on Learners of Native Language

The reason of the grammatical interference lies in the identity of grammatical forms existing in two languages, in our case between Azerbaijani and English languages. Typological differences in the Azerbaijani and the English languages are potential fields of grammatical interference. The real potential field of the grammatical interference in the speech of the Azerbaijani students covers just a part of grammatical interferences.

Grammatical Interference occurs when the elements of first language included in using a second language which shows itself in grammatical structure of the second language, word order, use of articles, pronouns, tense and mood etc.

In the English language the grammatical category of number is additionally supported by the grammatical category of definiteness and indefiniteness presented in the form of articles. (Koshevaya, 2008, p.34)

While using the English nouns, which differ from the Azerbaijani nouns in number, the articles undergo interference. For example, in the English language the indefinite article [*a, (an)*] is not used with the noun in plural. With such nouns the definite or zero articles are used. Depending on the absence of grammatical category of definiteness/indefiniteness in the Azerbaijani language, another grammatical interference takes place in the English speech of students. The students who forget that some nouns in the English language (*goods-mallar, clothes- paltar, people- adamlar, police - polis, stairs-pilləkən* and etc.) have only plural forms, they use the indefinite article with these nouns: *"The company got a new goods" (Şirkət yeni mallar alıb.), "A police has come there in a minute" (Polis oraya bir dəqiqədən sonra gəlib çıxdı.).*

The right use of articles in the examples like *"the company", "a minute"* tells of a higher level of proficiency in the English language, because the sign of interference here is a simple interference, it is the minimal linguistic unit of the bilingual speech. It influences on the deviation from the norms of the English

language on the same level of speech, while realizing the particular elements of the system of the language.

The study of interference of articles plays a great role in the study of grammatical interference in the speech of students, as the understanding of articles in the English language usually presents great difficulties for students. The students often omit the Indefinite and Definite articles, which are indicated in bold type in word combinations and sentences. For exmple as: ***the*** *most interesting,* ***the*** *greatest exporter, in* ***the*** *whole world,* ***the*** *people of Azerbaijan, to be* ***a*** *team leader, to write* ***a*** *thank you letter,* ***the*** *best, to take* ***the*** *first place,* ***the*** *countries of the third world, manager is* ***a*** *very important person, to be* ***a*** *very efficient specialist,* ***the*** *last reason, to learn* ***a*** *foreign language, to find* ***a*** *good job, he got* ***a*** *bad mark, my son is still* ***a*** *pupil, English is* ***an*** *international language, English is* ***a*** *very beautiful language, We need* ***an*** *umbrella stand, Could we have* ***the*** *invoice on Monday? Can we get* ***a*** *five percent discount?* Such abundance of grammatical interference in the speech of Azerbaijani students is due to the fact that the articles do not exist in the Azerbaijani language.

Thus, at various levels of proficiency in the English language the Azerbaijani students differently realize the potentials of interference: typological differences, because of the lack of grammatical category of definiteness / indefiniteness realized by articles, cause the regular interference at the initial stages of bilingualism.

The students and pupils often experience difficulties with the use of personal and possessive pronouns. For example, the English expression *"I like"*corresponds to the Azerbaijani word combination *"xoşuma gəlir"*. Because of differences in grammatical constructions of both languages, we find interference in the speech of students when they use this expression. They say *"**Me** like"* and *"**Me** likes"* substituting the personal pronoun in the nominative case *I* for the personal pronoun in indirect case *me* which corresponds to the Azerbaijani construction of the expression.

The verb *to let* and the corresponding personal pronoun in the indirect case are used to express an inducement, for example, *"Let him go home"* (*Qoy o evə getsin.*). Under the influence of Azerbaijani where in this sentence the personal pronoun in the nominative case is used, the students often use the corresponding personal pronoun in the nominative case in the English language *"Let **he** go home"*.

The issue of grammatical category of case in the English language remains debatable; however, the generally accepted view is that the case system of the English noun is presented by two cases: common and possessive. (Arakin, Vigodskaya, Iljina, 2000, p.289).

As the English language refers to analytical type of languages, but Azerbaijani to synthetical type of languages, then mainly prepositions in the English language perform the function of a link between the words and/or used for the

expression of object, adverbial and other relations which in Azerbaijani can be additionally or independently expressed by means of case forms of nouns and pronouns.

In English unlike Azerbaijani, nouns, as well as the pronouns in all the cases have no special endings. That's why, various relations in English are expressed by prepositions and word order in the sentence. Typological differences in the expression of various case relations create potentials for grammatical interference.

The expression of tenses by word order in the English language creates considerable difficulties for the Azerbaijani students. Thus, in the sentence *"Who will be able to meet tomorrow the delegation at the station?"* The students do not use the direct object after the verb, but after the adverbial modifier of time which is set at the end or at the beginning of the sentence. The right version is the following*: "Who will be able to meet the delegation at the station tomorrow?" (Kim sabah nümayəndə heyətini vağzalda qarşılayacaq?* or *Kim sabah nümayəndə heyətini vağzalda qarşılaya biləcək?).* Or, for example, the adverbs of the Indefinite Tense *always, often, seldom, never, usually* that are usually placed before the notional verbs or the verb *to be*. However, students often place these adverbs at any place in English sentences under the influence of the Azerbaijani language in which such adverbs have no fixed place in the sentence: *"What usually do you do in the evening?"* instead of *"What do you usually do in the evening?", "His lectures always have been interesting"* instead of *"His lectures have always been interesting", "He said that his parents had always lived in the country".*

The expression of spatial meaning of place by word order in the English language causes some difficulties for the Azerbaijani students. This happens while using the English expression *there is/there are* to denote the location of the subject or subjects.

The students often omit the expression *there is/there are* in the affirmative sentence. For example, the students translate the sentence *"Bizim mənzilimizdə 3 otaq var"* as *"In our flat 3 rooms"* instead of *"There are 3 rooms in our flat".* Such a word order in English corresponds to the one in Azerbaijani.

While formulating the interrogative sentence with the expression *there is/there are,* the students often omit them even identifying them in the affirmative sentence. For example, most of the students ask questions like this: *"How many windows in the room?" "There are three windows in the room",* omitting the expression *there is/there is*, and only in rare cases students ask question in the right way: *"How many windows are there in the room?"*

In some cases while formulating the English sentence the students do not omit the expression *there is/there are* using them not at the beginning but in other places of the sentence, which also breaks the

structure of the sentence. For example, the students break the structure of the English sentence in such examples: *"Hər kompaniyada işçi iyerarxiyası var"* by using the expression *there is/there are* in the place of the sentence where it must not be used: *"A hierarchy of employees **there is** in every company"*. In such sentences the expression ***there is/there are*** must stand at the beginning of the sentence: *"**There is** a hierarchy of employees in every company"*.

The students often forget about this expression substituting it with *to be* and *to have* in the sentences like *"Three windows are in the room" (Otaqda 3 pəncərə var.), "Our flat has two rooms" (Mənzilimizdə iki otaq var).*

The preposition ***of*** in English is used to form the genitive case of nouns while expressing the object, subject, attributive relations. However, under the influence of Azerbaijani, in which the endings are used to form the cases, the students always omit the preposition ***of*** in their speech. For example, one can come across such cases of deviation from the norm of English: *"This form business organization is the most important in Azerbaijan"* instead of *"This form **of** business organization is the most important in Azerbaijan", "I live in the town Ganja"* instead of *"I live in the town **of** Ganja", "the success an organization"* instead of *"the success **of** an organization", "expansion our company"* instead of *"expansion **of** our company", "the advantages this type of organization"* instead of *"the advantages **of** this type of organization".*

The use of preposition ***of*** instead of *by* to denote the authorship of art work is also one of the typical mistakes encountered in the speech of students: *"They read the books written **of** English writers"* instead of *"They read the books written **by** English writers".*

The students have some difficulties in using the preposition ***to*** in combination with nouns or pronouns for the expression of object meanings given in Azerbaijani with dative case without preposition. That's why, the students omit this preposition in the sentences like *"I showed my summer photos (to)[1] my friends", "When asked I always give my books (to) my friends", "When I have problems my parents always give some good advice (to) me".*

The preposition *by* and *with* used relatively to express a character or acting forces and the subject, which correspond to the instrumental case of Azerbaijani, without preposition always are interfered in the English speech of students. In their statements the students omit these prepositions, for example, in the sentences like *"St.Paul Cathedral was designed (by) sir Christopher Wren", "The idea of heating a house (with) fire is useful".*

The expression of various spatial meanings (direction, place, time, manner, cause and effect of action) are always given in the English language with prepositions. For example, the students have difficulties while expressing the meanings of direction or place, for instance, *go home (evə*

[1] The words in brackets are omitted in the speech of Azerbaijani students

getmək) and *to be at home (evdə olmaq)*, as in Azerbaijani the expression *evdə olmaq* is used without preposition, but in English it is used with the preposition *at* which points to the location in such expressions.

The students in their English speech often omit this preposition under the influence of Azerbaijani, for example, they often say and write *to be home*. Such deviations from the norm of the English language appear while using the expressions *məktəbdə olmaq,* that is, *məktəbin binasında olmaq - to be at school, işdə olmaq - to be at work.*

The expression of tense by way of prepositions present some difficulties for the Azerbaijani students. So, for example, preposition *on*, (*on Monday*, *on Friday* etc.) is used to denote the event occurred in some day of a week or the date in the English language. However, the students substitute this preposition *on* for *in* that corresponds to the azeri expression *Şənbə günü, Cümə günü.*

To denote the event occurred on some date in the English language the preposition *on* is also used: *on the tenth of December, on the ninth of May* (*dekabrın onu, mayın doqquzu).* In the Azerbaijani language such constructions are used without preposition that leads to the grammatical interference in the English speech of students as they always omit the preposition *on* or use the other ones, for example, *in* or *at*.

Thus, the wrong use of prepositions is due to the peculiarity of the subjective perception of their meanings by the people, speaking different languages. The result of such perception is the use of preposition on the analogy of the native language, as well as the transfer of such a use to similar cases of the foreign language.

Some differences in the grammatical categories of Azerbaijani and English adjectives and adverbs, for example, in the formation of the degrees of comparison, are also the potential field for the grammatical interference. In the formation of the degrees of comparison of the English adjectives and adverbs by the Azerbaijani students one can note the examples of the grammatical interference; in such cases where the students form the comparative and superlative degrees of the special group of adjectives and adverbs according to the common rules. For example, the students say *gooder* instead of *better* (comparative degree from the adjective *good*), and *badder* instead of *worse* (comparative degree from the adjective *bad*). In the other cases the students form the degrees of comparison of adjectives mixing up the rules, for example, they say *the most great* instead of *the greatest* (superlative degree from *great*). Such examples refer to intra-lingual interference as they are the result of intra-lingual analogy.

5. Results of the Analysis of Interference in the Speech of Azerbaijani Students in English

The numbers and the rates of the interference units in the speech of the Azerbaijani students have been observed in the first stage of mastering the English

language. The results of the experiment were carried out among the Azerbaijani students (266 students among 16 groups) chosen for the mentioned purpose. It is noteworthy to state that the influence of the potensial branch of the interference may be observed in all levels of the language. The examples taken from the oral and written speeches of the students may prove it. For instance, *Is your sun engineer or worker?* As it is seen, instead of the word *son* the word *sun* is used. The defect of the phonetic level of the word may cause the lexic-semantic interference of it as well. The interference in the grammar level is also possible. In the above mentioned example the articles before nouns *enginner* and *worker* have been omitted. The correct version of the sentence is *Is your son an engineer or a worker.* Another example:

The history (instead of the word *story*) *told* (the preposition *by* has been omitted) *him was very interesting.* The lexic-semantic interference may be observed here. The students used the word *history* instead of the word *story*. It happened by the cause of bilingual paranimia. This interference is seen in the grammatical level. The sign of the person performing the action is conditioned by the formation expressed by the help of the preposition "by" has been omitted. This difference of the catagory of case in the English and the Azerbaijani languages. Unlike the Azerbaijani language nouns as well as pronouns do not have any special endings in all cases in the English language, and existing various relations are expressed by prepositions. The following example can illustrate our thesis:

What you think at the new building?- The auxiliary verb "to do" which is used to form the interrogative and negative forms of the present indefinite tense form has been omitted by the students. It illustrates the interference in the grammatical level. The students also make mistakes while using the preposition *at* instead of *about.* The interference in the grammatical level is again observed. The correct variant of the sentence is *What **do** you think **about** the new building?*

My sun (the word ***sun*** is used instead of the word ***son***) *is still a pupil and he will finish school next year*. The defect in the phonetic level of the sentence as well as the lexical-semantical interference in the English speeches of the Azerbaijani students have appeared.

The complex interference is also possible in the speeches of the Azerbaijani students using the English language. The complex interference means "the linguistic unit of the second language speech which carries two or more defects in any unit of the second language speech" (Hashimov, 1972, p.230).

The following example can illustrate the complex interference in the grammatical level in the English language speeches of the Azerbaijani students. Instead of the sentence *I like **to** listen **to** English music* the sentence *I like listen English music* has been used. The particle *to* preceding the infinitive and the preposition *to* have been left out.

Let's consider the example of complex interference in the lexical-semantic level in the English speeches of the Azerbaijani students.

The English language gives you an opportunity ***to know*** *more about traditions and* ***costumes*** *of other nations.* The word ***to know*** is used insead of the word ***to learn,*** and the word ***costumes*** is used instead of the word ***customs.***

It is necessary to state that the simple interference is characterized by the weak interference in the English speeches of the Azerbaijani students. The simple interfernce expresses minimal linguistic unit in the second language "expresses the second language outside the norms in one level of the speech realized by the separate elements of lexis, phonetic, grammatic, or stylistic norms of the second language" (Hashimov, 1972,p. 227).

The learning of the interference does not cover the information which reveals the comparable analyses of the structures of the interfernce in the native language and the second language. The learning of the interference should base on the results of the mistakes made in the second language speech of the students. It states that the mistakes students make under the influence of the native language, form more than 50% percent of the mistakes of the speakers who speak in two languages (Karlinskiy,1978,p.52).

L.V.Sherba claimed: "It is not controversial that our native language becomes our enemy while learning a foreign language. It happens because our native language makes us make many mistakes while speaking the second language. Therefore, we must try to do our best for making it our friend. It is not difficult to do it. We should understand all cases where it misleads us" (Sherba, 1958, p. 43).

According to Sherba's opinion, from the speech activity viewpoint the deviations from the norms in the speeches of the bilingual very characteristic. Only they reveal the mechanism of this process. They just comprehend the reasons of the historical changes taking place in the language. The speech mistakes are very valuable materials for the linguist-theorist who considers the questions "how" and "why" to be very important (Sherba, 1958, p.188).

The basis of the characteristics of the mistakes contain its importance for the communicative act. They are:

1) The few mistakes for the communication act for instance, accent, etc.

2) The mistakes which do not disrupt the communication act but its meaning for instance, the misrepresentation of the meaning of the word, wrong connotation, inadequate lexical compatibility, etc.

3) The mistakes which make the communication act be impossible for instance, the disorder of the form and the meaning (Belchikov,1988, p.104).

Comparing the systems of the two languages, some certain typological

differences in various levels between them have been made known. This is especially observed in the English speeches of the Azerbaijani students in the field of potensial interference. The potensial interefence in the English speeches of the Azerbaijani students is observed in the early level of English-Azerbaijan bilingualism.

6. The Results of the Experiments

For the study of the process of interference in lexical-semantic and grammatical levels manifesting themselves in the English speech of the Azerbaijani students both certain phonetic, grammatical and lexical-semantic aspects, 1100 written works and their tape-recordings consisting of the duration of 225 minutes, including totally 990 texts and sentences have been investigated by us.

The offered linguistic exercises were the following ones:

Translation of word combinations, sentences and texts, consisting of different lexical-semantic and grammatical manifestations in the English language, causing some difficulties in understanding such examples in the phonetic, lexical-semantic and grammatical levels in the English speech of the learners in the process of interference, reading of the different English words and tongue-twisters which are seemingly hard to pronounce.

In 2090 texts and expressions, in both written and oral speeches of the students, for the first year students 1207 cases of diversion from the norms of English speech have been discovered all of which have been analyzed. Among these diversions were 179 phonetic diversions 390 lexical-semantic interference, and 638 cases of grammatical interference phenomena.

Among the second-year students 890 cases of diversions from the norms have been discovered. Out of these diversions are 161 phonetic interference, 248 lexical-semantic interference and 481 cases of diversions belong to grammatical interference phenomena.

Among III year students 632 cases of diversions from the norms have been discovered and analyzed. Out of these diversions are 124 phonetic interference, 77 lexical-semantic interference, 225 grammatical interference phenomena.

Among IV year students totally 382 cases of diversions from the speech norms have been discovered. Out of these diversions from the English speech norms are 80 phonetic interference, 77 lexical-semantic interference and 225 belong to the phenomena of grammatical interfrence.

While mastering the system of studied language, the students master the language phenomena, which do not exist in the native language or are the language phenomena different from the native language. Speech interference is linked with the real manifestation of one of the languages in the speech of bilingual in the second language, in the process of creation of speech products. Very often this process shows itself in the second language which is being learned. Absence of interference can be valued as the indecator of complete mastering of the second language by the students.

Thus, while comparing the language systems of the two languages (English and Azerbaijani languages) it is possible to discover certain typological distinctions in different levels of the both languages, which reflect themselves in the potential interference fields of the English language spoken by the Azerbaijani students. Potential fields of interferences manifest themselves more strongly in the initial stage of Azerbaijani-English bilingualism in the English speeches of the Azerbaijani students.

Conclusion

Typical deviations from English norms on a grammatical level are closely dependent on learners' command of English. The higher the command of English is, the more rarely and extensively the deviations from the norms of English grammar can be seen.

As it can be seen, interference on different levels is characterized by various intensities.

Grammatical interference can be regularly noted and is communicatively important in certain cases. The variety of interference phenomena in the English speech of students on a grammar level is mainly distinctive to the difference between Azerbaijani and English in terms of the grammatical system which constitutes a framework of language. In addition, it should be noted that some mistakes can be explained by the lack of attention, and "developmental disease" which is hard to challenge.

We think that it is too difficult to get rid of interference of native language by way of studying differences between native language and the studied language. It is necessary to master the basics of the studied language and as soon as it is possible to learn the studied language in the original, namely, one must study language in use, in other words, the languages must be separated at the very beginning as much as possible, so that when speaking English one can think not in Azerbaijani but in the language which he/she learns. However, one should realize and remember that the learner of a foreign language cannot avoid the influence of native language, and must try to consciously minimize the wrong effect of the native language or vice versa.

LONG ISLAND UNIV, CW POST COLL, ISSN:0010-5716 UNITED STATES

Reference

1. Arakin, V.D.; Vigodskaya, V.S.; Iljina, N.N. (2000). English – Russian dictionary . Moscow: Russian Publishing House.
2. Belchikov, Y.A. (1988). On the Cultural Connotative Component of Vocabulary. Language: systems and functions. Moscow: Progress.
3. Bloomfield, L. (1933). Language. New York. Henry Holt.
4. Diebold, A. (1961). Incipient Bilingualism. Vrije Universiteit Brussel. Honiton, Devon
5. Hashimov, M. (1972). Semantic Shift in Bilingualism. New in linguistics. Moscow: Progress.
6. Karlinskiy, A.E. (1978). On the Two Types of Manifestation of the Interaction of Languages. Psychological and linguistic aspects of the problems of language contacts. Kalinin:KQU.
7. Koshevaya, I.G. (2008). The Course of English - Russian Comparative Typology. Text.: teaching guide. Moscow: Visshaya Shkola.
8. Sherba, L.B. (1958). Some Conclusions from My Dialectical Peasant Observations. From the book "Selected works on linguistics and phonetics". Leningrad: Nauka Publishing House.
9. Sherba, L.B. (1974). On the Issue of Bilingualism. Language system and speech activity. Leningrad: Nauka Publishing House.
10. Vinogradov, V.A. (1990). Interference. Moscow: Nauka.
11. Weinreich, U. (1953). Languages in Contact: Findings and problems. New York.

Article

Warning signs and spectacularly deepening study

Harrison Douglas, Landy

Illinois University, USA

Harrison_landy@gmail.com

Abstract

It is not recommended to search for the footprints after dark and take note of all warning signs. But our group had not come to see the fossils. Instead we clambered over the sharp edges of the point's red ochre-coloured rock faces to find a perch where we could watch the setting sun. As with most days in Broome, or so I'm told, the sun's blazing red orb sank spectacularly into the distant horizon of the Indian ocean, lighting up the sky in a kaleidoscope of colour: red, yellow, orange and violet blue. The disappearing light soon cast a melancholic mood, reminding me of Michael Taussig's idea that 'in a beautiful sun-set we see deepening shadows of despair, and maybe this is why they are beautiful. In the late afternoon on my last day in Broome I travelled by mini-bus with several other out-of-towners from the seminar to Gantheaume Point. This is a place where tourists flock to see world-famous one-hundred-and-thirty-thousand-million-year-old fossils of dinosaur foot-prints. Broome's Tourist Information Centre warns that searching for traces from the past can be dangerous business: Be warned that the terrain becomes rough, steep, unstable and slippery. You should only attempt to climb down to the intertidal area if you are fit and healthy and wearing sturdy, non-slip footwear.

Keywords: allegory, image, self-mutilation, sensibility

LONG ISLAND UNIV, CW POST COLL, ISSN:0010-5716 UNITED STATES

Introduction

Yet, as this essay will argue, such a clear distinction between bodily and mental suffering cannot be made for all historical periods. The study of self-mutilation in later nineteenth-century psychiatry provides a fitting focus for examining the complexity of notions of body and mind in relation to ideas of pain. In Broome, Swain and Pigram are not alone in the cultural work of 'memory of tradition' of Australia's other cultural histories and alternative ways of being in the world. Indigenous cultural production as the continuation of Indigenous culture and as a living and continuously adapting culture is flourishing, from Wawili Pitjas' Jandamara (with ABC TV) and the popular culturally-based TV cooking show Kriol Kitchen to the beautiful songline animation In Pigram's words of warning. We need to be celebrating these [old] people and their knowledge, and learn from it … If we don't look to our first peoples and their understanding of tree, of land, of natural systems and the way things work, it's all going to disappear very quickly. And I have a feeling we're going to really need that knowledge soon. (cited in Brunes). In her influential text, *The Body in Pain*, Elaine Scarry made a stark division between physical and psychological pain, suggesting that while the latter has permeated almost every form of literature, the former receives little attention.1 Lurujarri Dreaming (Bernadette Trench-Thiedeman with Goolaraboolo community 2012), Goolarri Media's video-training workshops, Magabala Books' publication of works by more than 100 authors, the unique kriol sounds of the Pigram Brothers musical performance, and so on. In the western world the arts are often regarded as different to and separate from the world of politics. In Broome I was reminded that in Indigenous communities, cultural production is considered heavy-lifting and the means of ensuring trans-generational transfer of an Indigenous worldview, which, if we took the time to listen, is precisely what all the reports into Indigenous suicide prevention in Australia say must occur if we are committed to stopping this social emergency (Georgatos). As Marrugeku suggest through their work, such knowledge is crucial to an Indigenous understanding of culture and tradition. In this essay, I have tried to suggest that it is also a powerful critique of the discourse of progress and something we all need to learn if we hope to continue to live in this country, indeed if our fragile planet is to continue to sustain life and the different worlds we make for ourselves and our children.

Today, it is widely accepted that self-inflicted injuries hold psychological or emotional meaning, attached to the pain or ritual of inflicting a wound and the physical injury itself.2 Such has not always been the case. Indeed, for much of the nineteenth century discussion of self-mutilation tended to focus on the physical nature of wounds, rather than on the process of inflicting them, which, it was at first assumed, occurred simply from the inability of the individual to feel physical pain. In the later nineteenth century, however, some alienists (asylum psychiatrists) began to show an interest in examining the 'motives' behind self-inflicted injury and published increasingly on the topic. The reasons recorded certainly included the idea that self-mutilation might *relieve* rather than inflict pain, as Scarry suggests; nonetheless, the somatic language often employed in nineteenth-century descriptions of mental illness tended to mean this relief was ex-

pressed in physical rather than psychological terms.3

This essay provides an analysis of the overlapping ways in which self-inflicted injury was understood in relation to pain (or, more often, its absence) during the second half of the nineteenth century. Today, it is often assumed that self-mutilation in past centuries was closely associated with suicide: thus, I begin by exploring the complex way in which the topic of self-mutilation was associated with — and, more importantly, differentiated from — medical, legal, and cultural understandings of suicide. However, I will argue that it is a mistake to read late nineteenth-century British texts solely from this preserve. Physiological and psychological meaning is often hard to untangle in the published texts of asylum psychiatrists, and still more so in asylum records. Their interest in motive cannot thus be regarded as either a simple forerunner of psychological approaches to mind *or* a purely somatic understanding of brain mechanism. Rather, as I show in a comparison of British psychiatric approaches, asylum physicians preferred a socio-environmental approach to the symptoms of mental illness. Finally, I look at two seemingly psychological approaches to self-mutilation — those of Richard von Krafft-Ebing and William James — both referenced by British physicians writing on the topic. Despite the alleged psychological context, ideas of sensation continued to permeate such research at the turn of the twentieth century. I conclude that a study of self-mutilation — a topic associated in various ways with pain and suffering — indicates that we cannot view later nineteenth-century psychiatric ideas in terms of the modern separation between physical and psychological pain.

My research focuses on the published texts of British alienists (and European and American texts cited by them), within the period 1860 to 1900, when the bulk of writing on self-mutilation outside a military context appeared. In addition, I explore the asylum practices of those writing on the topic, including George Savage, Theo Hyslop, and Daniel Hack Tuke (all variously associated with the Bethlem Royal Hospital), and James Adam (superintendent of the Crichton Royal Institution in Dumfries and, later, West Malling Place Asylum). The views of these elite practitioners should not be taken as reflecting the opinions of all alienists of this period. Their involvement in teaching and research (in most instances) may have contributed to their interest in a field of investigation that was not necessarily the focus of all — or even many — of their contemporaries, while their experiences with wealthy or educated patients may also have shaped the field of discussion.4 Nonetheless, their ideas certainly emerged from their asylum practice, and many of these alienists were also highly regarded spokesmen for the asylum system. Their efforts to define and explain the topic of 'self-mutilation' can, therefore, shed much light on general asylum approaches of the period. These, I will

LONG ISLAND UNIV, CW POST COLL, ISSN:0010-5716 UNITED STATES

argue, were not solely based around concerns with heredity and a tendency to view mental disorder in somatic terms, but also incorporated social and even psychological influences.

Throughout the essay, I will use the terms 'self-injury' and 'self-mutilation' interchangeably to refer to all types of self-inflicted injury — including, but not limited to, amputation, enucleation (plucking out the eye), castration, hair-plucking, and the creation of cuts, bruises, and other skin lesions. Such reflects the nineteenth-century usage of both terms, which were very broadly defined by alienists and those around them.5

Self-Mutilation and Suicide

More recent texts within psychology, psychiatry, and, at times, the history of medicine, tend to assume a close relationship between self-inflicted injury and suicide. This might reflect the emphasis placed by contemporary clinicians on Karl Menninger's landmark study, *Man Against Himself* (1938). The psychoanalytically oriented Menninger regarded self-mutilation as an unconscious mechanism for *avoiding* suicide in the individual, by the concentration of a 'suicidal impulse' on one part of the body as a substitute for the whole. Self-inflicted injuries — including 'self-mutilation, malingering, compulsive polysurgery', and 'certain unconsciously purposive accidents' — were thus incorporated by Menninger under the banner of 'focal suicide'.6 Modern texts (including the only book-length work on self-mutilation, psychiatrist Armando Favazza's *Bodies Under Siege*) often cite Menninger as the first doctor to regard self-mutilation as a topic worthy of discussion, assuming that earlier physicians made no distinction between self-mutilation and suicidal acts.7 Thus, while suicide has received much attention in medical history, other forms of self-inflicted injury have not. For some, self-mutilation appears to be a clear-cut category, an attitude that has also prevailed in discussion of attempted suicide.8 Similarly, histories of suicide either bypass self-mutilation altogether or fail to acknowledge any distinction — lay or medical — between suicide and other forms of self-inflicted injury prior to the twentieth century, conveying the erroneous impression that none was made. For example, while claiming to discuss the 'History of Suicide and Self Harm', a chapter of German Berrios's work on mental symptoms focuses solely on published literature on suicide.9 The few critical histories of self-mutilation — investigating the way in which ideas of self-harm have been formulated — focus on twentieth-century ideas.10

Yet late nineteenth-century alienists certainly *did* draw a distinction between self-mutilation and suicidal acts. Indeed, as early as 1844, standardized admission papers to the Bethlem Royal Hospital enquired whether a patient was 'disposed to suicide, or otherwise to self-injury', suggesting separate, albeit related, symptoms of mental disorder.11 From the late 1860s, the term 'self-mutilation' increasingly began to appear in published psychiatric papers and asylum case-books, as well as in newspaper articles declaring certain acts to be

'self-mutilation from insanity'.12 Alienists in the later nineteenth century frequently referred to the importance of distinguishing self-mutilation from suicide, although they rarely cited the reason for such distinctions.13 Sometimes, this emphasis may have been to protect the reputation of the asylum, for the public and Lunacy Commissioners alike regarded suicides in asylums as tantamount to neglect (Shepherd and Wright, pp. 175–96). In the Ipswich Asylum Annual Report for 1871, for example, the medical superintendent discussed a case in which a patient died several weeks after having torn out his eye, stating that 'the only remark I should wish to make upon this case is that I never considered it one of suicide, but simply one of self-mutilation'.14 Self-mutilation, although essentially related to suicide, might be presented quite differently: more akin to accidental injury than intentional act. Thus, in the same report from Ipswich, a list of 'accidents' included 'one patient [who] bit off the first joint of her little finger whilst in a state of epileptic delirium' (p. 274). Self-mutilation, like the term 'self-homicide', did not necessarily imply intent.15 Such a distinction between self-mutilation and suicide also served to protect the patient (and his or her family) from the legal and religious consequences of suicide and, indeed, attempted suicide, which had been newly criminalized mid-century (Anderson, p. 263).

Physiology and the Somatic Model of Self-Mutilation

However, for some commentators suicide was depicted as *less* unpleasant and more likely to be rational than self-mutilation. Although suicide went against the supposed 'natural instinct' of self-preservation, it had long been philosophically linked with rational behaviour, a connection which was increasingly emphasized with the revival of Stoicism in the later nineteenth century.16 But where did self-mutilation fit in relation to 'natural' processes, and what did its occurrence mean? In the 1930s, Menninger warned that his chapter on self-mutilation 'is not very pleasant subject matter. Our experience with pain makes the thought of self-mutilation even more repugnant than the thought of suicide' (Menninger, p. 203). Similarly, discussion of self-mutilation in the previous century was closely connected to philosophies of pain, in particular, the influence of Jeremy Bentham's pleasure/pain model of motivation in mankind (1789), promoted in mid-nineteenth-century psychology by the work of Alexander Bain (despite rejecting other tenets of Utilitarianism, including the 'greatest happiness principle').17 Bain's emphasis on pain and pleasure as the 'two great primary manifestations of our nature' included allusions to physical experience and mental function, using the terms to apply also to misery and happiness (Bain, pp. 31–32). He has thus been well-recognized as playing an important part in the proliferation of parallels between physiological and psychological models of mental action.18 This

LONG ISLAND UNIV, CW POST COLL, ISSN:0010-5716 UNITED STATES

philosophical approach to pain, in which 'a pain that did not prompt some alleviating action would be no pain', encouraged psychiatrists to emphasize the role of the absence of pain in the self-infliction of injury (Bain, p. 346). In 1875, for example, forensic psychiatrist Richard von Krafft-Ebing claimed that the 'loss of the pain-sense is of great significance in insanity', for it 'may lead to intentional self-injury, brutality in the manner of carrying out suicide […] [or] accidents'.19 Since a brutal suicide would presumably have the same result (physically, legally, and spiritually) as any more peaceful method, one might wonder why Krafft-Ebing should stress this as a particular concern. Moreover, how could absence of pain be regarded as a motivating factor in self-inflicted injury which did not have a suicidal purpose?

[2]

The construction of a model of self-mutilation based on the supposed perversion of 'natural' instincts towards pain was promulgated by Wilhelm Griesinger (1817–1868). A German neurologist and psychiatrist, Griesinger explicitly rejected traditional psychological and metaphysical classifications of mental disorder. These took into account the manner in which an insane person's speech, demeanour, or actions differed from those in normal life. Instead, Griesinger preferred a division into psychical depression, exaltation, and debility.20 This means of classification, he hoped, would assist in uncovering associated lesions in the brain and nervous system, thus furthering the medico-scientific side of psychology, rooting diagnoses in neurological research into impulse and inhibition.21 Although most psychiatrists, in Britain and Continental Europe, agreed that much investigation was needed before the biological nature of insanity could be firmly established, Griesinger further suggested that, in the absence of hard evidence of pathological change, diagnoses must be made along the 'entire collection of nervous symptoms', including anomalies of sensation and motion. He divided such irregularities into 'anomalies of sensibility' and 'disorder of the motor power', indicating a number of subcategories in each group. Rather than being a psychical symptom, Griesinger associated self-mutilation with those insanities marked by 'decreased sensibility, by anaesthesia or analgesia'. He cited the example of a patient who 'in part from wantonness, and in part to compel the attendant to send for the physician, had deliberately smashed the first phalanx of his thumb with a brick. This man told me he had not suffered the least pain' (Griesinger, p. 539). Thus, for Griesinger, elevating the status of the physiological symptom meant that the direct motive for self-mutilation could be discarded: the lack of pain was the causatory factor, not the patient's desired result.

While Griesinger's physiological aetiology of insanity was not adopted outright within British psychiatry, the view that self-inflicted injury was based on a combination of the absence of sensation and the influence of an 'insane impulse' often appeared in texts published in the second half of the century. When zoologist William Carmichael McIntosh discussed the topic in a

paper 'On Some of the Varieties of Morbid Impulse and Perverted Instinct' two years later, he typified the British approach, connecting a somatic neurological basis with the environmental and hereditary factors thought to influence moral and emotional insanity:

It is found that persons will occasionally castrate themselves, amputate their arms and legs by means of a passing railway train, cut, tear, and burn their bodies, and perform other impulsive acts of torture. Amongst the insane many marked cases are observed.22

If 'many' (rather than all) such acts were symptoms of insanity, this could suggest that some might not be. This issue increasingly became a topic of discussion in the last decades of the century as self-inflicted injury became commonly associated with so-called 'nervous disorders', in particular the 'cutaneous anaesthesia' commonly regarded as a major symptom of hysteria. Nonetheless, in case-studies of self-mutilation published in the Journal of Mental Science from the 1870s, the topic of sensation (and its absence) was often a major focus, used to emphasize the manner in which self-mutilation contravened natural laws.23

[4]

Despite the claimed objectivity of such an approach to self-inflicted injury, classification relied on doctors' reports that patients themselves confirmed that they had, indeed, felt no pain. Griesinger's example is complicated by his inclusion of the other motives cited by his patient, despite having claimed such concerns to be irrelevant within his scheme. As Michael J. Clark has since recognized, new physiological approaches to mental disorder in this period frequently remained complicated by metaphysical or psychological concerns.24When looking at nineteenth-century depictions of self-mutilation, therefore, we cannot attempt to make any clear divide between physiological and psychological interpretations of behaviour. Indeed, in Britain at least, the majority of those alienists who discussed self-mutilation in the later nineteenth century rejected rigidly somatic interpretations of illness. Savage, for example, was an outspoken critic of Henry Maudsley's 'tyranny of organization': the claim that mental illness was biologically inherited, and thus the inevitable fate of those born of 'nervous' stock.25 Theo Hyslop, meanwhile, emphatically rejected so-called 'medical materialism': the assumption that mental illness could be explained and understood through brain biology alone.26 The difficulties in making distinctions between the mental and physical are brought into clear relief by a closer examination of the case-books kept by these practitioners, which also indicate the complex way in which the interpretation of self-mutilation relied on interaction between doctors and patients. The examination of asylum practice alongside published texts can thus offer us greater insight into psychiatric ideas of the period: theory and practice were not necessarily one and the same.

James Adam, for example, who wrote the five-page definition of 'self-mutilation' for Daniel Hack Tuke's Dictionary of Psychological Medicine (1892), made explicit reference to examples of what he termed 'sexual self-mutilation' in his published definition (p. 1150). This category drew heavily on one particular case he had encountered at West Malling Place. On examining the case records, however, it becomes evident that this was the onlycase of self-mutilation recorded during Adam's ownership of the institution: the relatively rare occurrence of such acts as reported within asylums indicates that we cannot see classifications as simple descriptions of the occurrences of asylum life.27 Instead, definitions were created by bringing together unrelated instances reported by a variety of practitioners. Adam's patient, Captain Henry Puge Halhed, had been admitted to West Malling Place in April 1871, aged 65, over a decade before Adam purchased the institution. Halhed had previously been a Captain in the Bengal Army and, about five years before his admission to West Malling Place, had 'removed the testes & part of the scrotum [...] having the impression he must become a Eunuch to preach to a tribe in the North of India'.28Halhed's ideas were interpreted as religious and sexual delusions by both Adam and his predecessor, Thomas Lowry, although little reference was made in case-books to the somatic context referred to in published works, beyond vague allusions to 'impulse' (a term that could be interpreted both neurologically and psychologically). Indeed, the main focus lay in locating Halhed's self-mutilation within his prior experiences: anxiety over his sexual role, 'religious enthusiasm and excitement', and, in the Dictionary, the acquisition of 'Eastern languages and ways' (Adam, p. 1150). Such an explanation offered a socio-environmental account of self-inflicted injury (in addition to the influence of inherited physical traits located within the individual). Indeed, in his published definition, Adam declared that the only way to understand self-mutilation was by 'an endeavour to trace some of the motives which have prompted to the commission of the acts' (p. 1147): an idea that certainly did not fit within the physiological model proposed by Griesinger, but shows closer links to Bain's associationist psychology.

Like Adam, late nineteenth-century Bethlem physicians George Savage and Theo Hyslop set much store in uncovering the 'motive power' of insane patients.29 Indeed, the socio-environmental model of madness that these physicians shared seems to have encouraged their interest in self-inflicted injury. But what 'motives' did these psychiatrists 'discover' in their patients? Sometimes, these did indeed fit the somatic model of self-injury offered by Griesinger. In 1889, for example, when Isabella Morant was admitted to Bethlem after attempting to cut off her hand with a carving knife (after which it had been amputated), her husband reported that she 'said she had no pain'. While in hospital, Isabella further managed to tear out one eye — something she had long threatened — and the medical officers again reported that 'there has been little or no pain', while the

patient 'says she is very happy now & does not intend to do any further injury'.30 However, plenty of other patients did not fit this neat model based around sensation. In the Bethlem Hospital case notes, two other explanations put forward frequently by patients also focused on pain in very different ways: by interpreting self-injury as punishment, or as a form of treatment for pain they were currently experiencing.

While Isabella Morant indicated that her actions (both amputation and enucleation) had been required by a higher power, other patients suggested their injuries were atonement for crimes. Such concepts of punishment often did assume that injuries were painful: for example, although Frederick Humphreys's efforts to burn his arms were interpreted as punishment, the patient apparently claimed that he had trained himself to bear the pain.31This notion of self-mutilation as a form of 'endurance' was sometimes suggested to be a motive behind self-inflicted injuries in sanity as well. Other patients claimed that their injuries, while not painful in themselves, provided 'relief' from other pains they had to bear: such suggestions were almost always couched in physical, rather than mental, terms. An interesting example is self-cutting, which, unlike today, was rarely specified as a distinct form of self-mutilation, possibly due to an alternative framework of interpretation located within medical treatment: phlebotomy, or bloodletting. In 1860, Elizabeth Taylor was reported as having shown

> latterly some indications of a wish to injure herself, […] to draw blood which she fancies would relieve her [On one occasion] […] without any obvious cause or previously speaking of it, she rushed into a chemist's shop & asked to be cupped immediately, as the only means to relieve the distress of her head.32

The complicated dialogue here between self-injury and self-treatment is apparent. Although a practice discarded by many physicians by the mid-nineteenth century, bloodletting was still widely available as a treatment for any type of illness, making it hard to define Taylor's actions as self-mutilating.33 Thus, although her sudden unexpected need for bloodletting was regarded as unusual, it was presented as little different from a compulsion to bathe; it was the perceived lack of reason and the 'supernatural voices' heard, rather than the behaviour itself, which was seen to evidence mental illness. Some twenty years later, George Joblin also reported injuring himself to 'relieve the pressure in his head'; while as late as 1900, 56-year-old Alexander McCullock declared 'that he had bled himself with a razor, because medical men were not now allowed to bleed and this relieved his head'.34 This alternative physiological understanding of self-mutilation did not require any specific information as to whether the injuries themselves were in any way painful: even if they were, this

could simply be dismissed as a side-effect of treatment.

When self-injury was declared to relieve pain, what did such an idea actually mean? Today, we tend to interpret physical pain as providing potential relief from mental suffering, but these distinctions are hard to draw in nineteenth-century cases. Elizabeth Taylor, for example, spoke of 'relief' to her head, which might have indicated the easing of physical pressure (for she complained of frequent headaches) or of unspecific mental strain. Such conflation is particularly evident in the case of one young student admitted to Bethlem in 1889, when multiple explanations appear in the casebook for the same act. A private attendant prior to hospitalization stated that Charles Hipwood had cut his face because 'he liked to see the blood that followed'. Hipwood's mother, meanwhile, claimed her son told her he cut himself because 'he wanted to see if he could feel anything'. Yet, in Bethlem, an alternative explanation was implied. Although the doctors found it hard to get anything out of their patient at all, he did tell them 'that he does not want to live & hints at something dreadful that is going to happen & at great suffering which he will have to bear'. Following this, the doctors conjectured (not deeming his injuries serious enough to be interpreted as suicidal) that 'he is apparently trying to prepare himself [for this] by inflicting pain on himself now'.35 Both of the latter two explanations emphasize the proximity of physical and mental suffering in a system of medicine which assumed a close relation between bodily and mental states. Charles had apparently told his mother that 'he had been a humbug all his life & unfit to live', that he was 'ungrateful' and 'insensible to anything', following which he cut his face in three places with a knife. Similarly, in 1892, Charlotte Nash Young was reported as having 'said that she had no feeling & cut her arms, thinks that she has no blood in her body [...] and bit herself on the wrist to see if it would bleed'.36The analogy between the biological language of nerves and circulation and the moral language of emotional propriety is apparent in both cases: 'no feeling' might refer to physical sensation or emotional state. Charles Hipwood continued to make a link between nervous and moral breakdown in his letters to Bethlem following discharge, clearly reflecting the contemporary conflation between physical and emotional sensation. Such ideas remain bound up in the approaches outlined below, which, while ostensibly psychological in tone, were nonetheless rooted in the foregoing physiological debate.

Between Somatic Reasoning and Psychological Meaning

When James Adam wrote of 'sexual self-mutilation', he referred his readers to the Psychopathia Sexualis of Richard von Krafft-Ebing, first published in German in 1886 (Adam, p. 1150). But what approach would interested parties have encountered in Krafft-Ebing's work, and how did it relate to the classifications of British alienists like Adam? Acknowledging the influence of Griesinger, Krafft-Ebing readily accepted the idea that self-inflicted injury resulted primarily from the failure of asylum patients to feel physical pain. However, a gen-

eration younger, Krafft-Ebing's writings were influenced by shifting ideas in Western European thought: most obviously, a commitment to altruism, emotion, and social feeling as the primary factors in the development of civilization. These concerns increased the use of parallels between physical and emotional sensation, while emphasizing the importance of sensation in the maintenance of social order.37 It is for his work on sexual pathology that Krafft-Ebing is best remembered today, and there has been much historical interest in his writings on homosexuality in particular.38 Less attention, however, has been paid to the way in which early editions of his magnum opus, Psychopathia Sexualis, created categories of pathology based on sensation. Such included both sexual hyperaesthesia (excessive sexual feeling) and anaesthesia (absence of feeling). The latter appeared particularly threatening to late nineteenth-century civilization, for Krafft-Ebing justified his research by building on the suggestions of British alienists (specifically Henry Maudsley) that sexual feeling formed the basis for social advancement, claiming that

sexual life is no doubt the one mighty factor in the individual and social relations of man that discloses his powers of activity, of acquiring property, of establishing a home, and of awakening altruistic sentiments toward a person of the opposite sex, toward his own issue, as well as toward the whole human race.39

When broken down, such a statement can appear mystifying to a twenty-first-century reader in some areas (what can sex have to do with acquiring property?) and exaggerated in others. Yet many of his claims are closely connected to the ideas of his contemporaries: Darwin, Spencer, and well-known evolutionary anthropologists had all viewed the development of 'sympathy' or 'altruistic sentiments' as the highest achievement of mankind.40 Maudsley and other alienists claimed that such sentiments were developed in puberty, thus assuming that the acquisition of moral feeling was closely associated with physical (sexual) development.41

So, how did Krafft-Ebing incorporate self-inflicted injury into this model? Although the categories of 'sadism' and 'masochism' were added to the 1890 edition of Psychopathia Sexualis (and thus available to Adam in writing his 1892 definition of 'self-mutilation'), none of the case-studies referring to self-mutilation appear under these headings.42Instead, the most complete case of 'sexual self-mutilation' is incorporated into 'sexual anaesthesia'. One of Krafft-Ebing's earliest published cases concerned E., a thirty-year-old journeyman painter.43 Krafft-Ebing was called as a medical witness after E. was arrested,

while trying to cut off the scrotum of a boy he had caught in the woods. He reported that he wished to cut it off so that the world would not multiply. Often in his youth, for the same reason, he had cut into his own genitals. (p. 67)

Voicing the Malthusian idea that population growth would inevitably out-

strip natural resources, E.'s concerns acted out the fears of many others, for he felt that 'it was better to castrate all children than to allow others to come into the world, and whose only fate would be to endure poverty and misery'. On Krafft-Ebing's testimony, E. was judged insane, and sent to an asylum rather than prison. This judgment meant that E.'s concerns about procreation and the poverty of his own childhood could also be dismissed as irrational. Instead, Krafft-Ebing's emphasis lay in an association between E.'s violent acts (both to himself and others), his lack of desire for 'normal' sexual intercourse, and his personality. Given the writer's strong belief in the altruistic potential of sexual activity, it is hardly surprising that he found E. 'selfish and weak-minded', 'moody, defiant, irritable' and a lover of solitude. Conclusively, Krafft-Ebing declared that 'social feelings were absolutely foreign to him' (Krafft-Ebing (1999), p. 68). Interestingly, E. did, in fact, feel physical pain: Krafft-Ebing noted that the patient's attempts at 'self-emasculation' had not been carried out because of pain. Nonetheless, this brief note was not allowed to detract from an overall correlation between the absence of physical (sexual) feeling and a lack of emotional and social feeling. Reports in British journals made similar analogies in cases of self-mutilation. When a young farmer, Isaac Brooks, was reported as having twice attempted to castrate himself in 1882, medical journals saw Brooks's 'eccentric, solitary, and reserved habits' as having led directly to self-injury: his lack of social (and thus, it was assumed, physical) feeling was viewed as having precipitated the act.44

This correlation between physical and emotional anaesthesia was also frequently made in the diagnosis of hysteria in the same period. Cutaneous anaesthesia was regarded as a common symptom of nervous illness, and doctors in hospitals for nervous diseases (such as the National Hospital at Queen Square) frequently carried out sensation tests on their patients with the use of a pin. Despite commenting on the suggestibility of hysterical subjects, these physicians seemed to see little problem in searching for anaesthesia, with the result that, according to Sydney Coupland at the Middlesex Hospital, they usually found it (Coupland, p. 644). Such an approach occurred in asylums as well as general hospitals, with the location of physiological symptoms at times overruling the subjective experiences of the patient.

Edith Mary Ellen Blyth was admitted to Bethlem in February 1893, aged thirty. She had been considered to be suffering from hysteria for five years prior to her admission to Bethlem with a diagnosis of mania, during which time she was seen by 'over 20 doctors' for an apparent skin disease, until 'last June [she] was taken to Mr Treves who said the sores were self-inflicted and they ceased to appear soon after this'. Edith was admitted to Bethlem for the most part, it seems, due to her renewed engagement in acts of self-mutilation. Nonetheless, her case certainly did not seem to prove the oft-posited link between self-inflicted injury and anaesthesia: the 'hysterical symptoms' to which she

had been subject for eleven years — 'inability to walk, to see, to speak & faints' — did not include a loss of sensitivity to pain. Indeed, Edith gave clinical assistant Dr Rivers a detailed account of her injuries, which, she reportedly said, 'were done by scraping with a pair of scissors, and rubbing in ammonia afterwards. […] The process was accompanied with considerable pain but that she felt an uncontrollable impulse to do it.' Subsequent to admission, however, Edith's sensibility was examined using a pin and it was claimed that much 'anaesthesia and hemianalgesia' was found: the patient's subjective claim that she felt pain could now be doubted — and even discarded.45

Rivers' detailed account of Edith's case is just one among many examples which indicate that the main interest for many doctors lay in the history of the injury itself (when, where, and how it was created) and the details of treatment leading to the discovery of self-infliction.46 Indeed, while the above quotation appears to indicate some interest in *why* Edith might have inflicted injuries upon herself, in the full case notes this is subsumed within a detailed account of the 'when' and 'where', and is nowhere the main focus of enquiry. The patient's claim that her self-inflicted injuries were the result of forces she could not control does not appear to have been accepted. Rather than either regarding her injuries as irrational symptoms of mental illness *or* exploring any deeper psychological meaning in the infliction of her wounds, much of Edith's treatment appears to have been explicitly moral (in both senses of the word). Both Rivers and his colleague Maurice Craig repeatedly tried to impress upon the patient that her actions were 'wrong', puzzled by her insistence that she had no intention of deceiving anybody and never realised for one moment she was doing anything she ought not to do and thought the remedies prescribed for her would cure her. When shewn the folly of this she said she 'did not put two and two together.' She recognises that it is a disgraceful thing to have such injuries but thinks she has done nothing wrong because she could not help it.47

The implication here is that, although Edith might have been certified insane (and thus irrational), she could, nonetheless, control her behaviour. Indeed, further notes regularly complained about the patient's troublesome behaviour in the asylum, where she consistently bit, scratched, and attempted to set fire to herself, and she was discharged uncured after less than eight months (the rules of Bethlem usually allowed patients at least a year of treatment). Although the attitude was perhaps kinder than that of Edith's mother who 'for 3 years […] has suspected that […] [Edith] made the sores on her legs worse & has not been sympathetic in any way', the understanding of Edith's self-mutilation was located within the widespread medical and popular view of the hysterical patient as manipulative and attention-seeking.48

The connection between self-inflicted injury, absence of pain, and 'selfish' behav-

iour was drawn most explicitly in William James's well-known paper on emotion.49 James's theory of emotions, published in *Mind* in 1884 and incorporated into his well-known textbook, *Principles of Psychology* (1890),has influenced much twentieth-century work on the topic.50In what is often regarded as an unusually materialistic stance, James suggested that, rather than accompanyingemotional ideas, physiological change in the body preceded — and even *caused* — emotional feeling. Despite much disagreement at the time, and the existence of a number of opposing theories, James's view has dominated much twentieth-century Anglo-American thought on emotions and affect, in particular Robert Plutchik's well-known 'basic theory of emotions', which suggested an evolutionary 'fight or flight' component to human feeling.51 Drawing a parallel between normal and abnormal psychology, James suggested that his theory might be supported by observing the behaviour of individuals who experienced no physical sensation. Indeed, it would prove a 'strong presumption' in favour of his hypothesis if a 'case of complete internal and external corporeal anaesthesia, without motor alteration or alteration of intelligence except emotional apathy' were found. The obvious starting point here, for James, was the asylum, and he referred to several articles by contemporary German alienists as a hesitant test of his theory, before calling for 'asylum-physicians and nervous specialists [to] begin methodically to study the relation between anaesthesia and emotional apathy' (James, pp. 203–04). Self-inflicted injury would, no doubt, have seemed an obvious starting point.

Conclusion

It does not appear that James's suggestions for further study were taken up to any extent, at least in British asylums. Nonetheless, they formed part of a system of medical (and lay) understanding which claimed a close relation between physical and psychological feeling: with insanity often characterized as showing an absence of both. This, as I have argued, was one of the important areas in which self-mutilation was distinguished from suicide, although the two topics certainly remained related. Self-inflicted injury was initially suggested by Griesinger and other physiological psychiatrists to be an objective symptom of insanity due to its assumed relation to absence of pain (a model of feeling not necessarily posited in cases perceived to be suicidal, which were more often understood in relation to a rational model of suicide as an *escape* from pain). Nonetheless, such ideas were complicated within British asylum practice by the emphasis on self-mutilation as a response to both an absence and an *excess* of pain. As the use of asylum case-books in conjunction with published texts has indicated, the reporting of cases of self-mutilation cannot be seen simply as a description of the realities of asylum life. Instead, reports of self-mutilation were constructed by patients and doctors in a multi-layered process, drawing on the prior experiences reported by the patient, medical views of the role of sensation and its absence in mental disorder, and the cultural significance of emotional and moral feeling.

This socio-environmental approach to self-mutilation is apparent in the approaches of physicians towards other symptoms of mental illness, such as the 'sexual anaesthesia' of Richard von Krafft-Ebing. It did not, moreover, preclude censure of the patient — as in the case of Edith Blyth — suggesting that absence of feeling was deemed to be located in the individual's biology or character, as well as in their socio-environmental context. Nonetheless, the two approaches were mutually constitutive: situating the onset of the individual's disorder in social concerns *as well as* regarding the insane individual as a potential danger to social order. For some writers in the late nineteenth century, as I have shown elsewhere, self-mutilation became synonymous with 'selfishness': an inability to respond to the 'altruistic sentiments' regarded as vital for the progress of civilization.52 This did not, however, rule out the simultaneous interpretation of self-inflicted injury as a response to emotional (societally created) pain. In either instance, however, it is impossible to draw a sharp distinction between physical and emotional pain, both within the topic of self-mutilation and in wider psychiatric discourse, opening up broader questions about the relationship of body to mind in psychological medicine in the late nineteenth century.

References:

1. James Adam, 'Self-Mutilation', in *A Dictionary of Psychological Medicine*, ed. by Daniel Hack Tuke (London: Churchill, 1892), pp. 1147–52; P.

2.See Armando R. Favazza, *Bodies Under Siege: Self-Mutilation and Body Modification in Culture and Psychiatry* (Baltimore: Johns Hopkins University Press, 1996), pp. 243–53; E. David Klonsky, 'The Functions of Deliberate Self-Injury: A Review of the Evidence', *Clinical Psychology Review*, 27 (2007), 226–39.

3. Scarry, in contrast, assumes that the relief of one pain by another must be the substitution of physical for psychological pain (pp. 33–34). See also Roselyne Rey, *History of Pain* (Paris: La Découverte, 1993), pp. 105–07.

4. Elaine Scarry, *The Body in Pain: The Making and Unmaking of the World* (New York: Oxford University Press, 1985), p. 11.

5. See Maury Deas, 'The Uses and Limitations of Mechanical Restraint as a Means of Treatment of the Insane', *Journal of Mental Science*, 42 (1896), 102–13.

6. Karl A. Menninger, *Man Against Himself* (San Diego: Harcourt Brace Jovanovich, 1985), pp. 201–308.

7. Favazza, p. 232. See also Margaret McAllister, 'Multiple Meanings of Self Harm: A Critical Review', *International Journal of Mental Health Nursing*, 12 (2003), 177–85;

LONG ISLAND UNIV, CW POST COLL, ISSN:0010-5716 UNITED STATES

Barent W. Walsh and Paul M. Rosen, *Self-Mutilation: Theory, Research, and Treatment* (New York: Guilford Press, 1988); P. M. Rosen and B. W. Walsh, 'Patterns of Contagion in Self-Mutilation Epidemics', *American Journal of Psychiatry*, 146 (1989), 656–58; B. Parry-Jones and W. L. Parry-Jones, 'Self-Mutilation in Four Historical Cases of Bulimia', *British Journal of Psychiatry*, 163 (1993), 394–402.

8. A forthcoming article by Åsa Jansson makes an important step towards filling this gap in scholarship, highlighting the way in which historians have assumed the existence of a 'real' number of suicidal asylum patients, thus failing to explore how the idea of a person *being* suicidal emerged. Åsa Jansson, 'From Statistics to Diagnostics: Medical Certificates, Melancholia, and "Suicidal Propensities" in Victorian Medicine', *Journal of Social History*, 46 (2013, forthcoming). For previous work, see, in particular, Olive Anderson, *Suicide in Victorian and Edwardian England* (Oxford: Clarendon Press, 1987), pp. 263–417; Anne Shepherd and David Wright, 'Madness, Suicide and the Victorian Asylum: Attempted Self-Murder in the Age of Non-Restraint', *Medical History*, 46 (2002), 175–96.

9. G. E. Berrios, *The History of Mental Symptoms: Descriptive Psychopathology since the Nineteenth Century* (Cambridge: Cambridge University Press, 1995), pp. 443–54.

10. Barbara J. Brickman, '"Delicate" Cutters: Gendered Self-Mutilation and Attractive Flesh in Medical Discourse', *Body & Society*, 10 (2004), 87–111; C. Millard, 'Self-Mutilation and a Psychiatric Syndrome: Emergence, Exclusions & Contexts (1967–1976)' (unpublished master's thesis, University of York, 2007).

11. This question was not altered until Bethlem belatedly became incorporated under the Lunacy Acts in 1853, and the reception order required under the 1845 Act (which referred only to suicide) was adopted.

12. 'The Case of the Farmer Brooks', *The Lancet*, 119 (1882), 73. Newspapers repeated this quotation verbatim. See, for example, F. W. Warrington, 'The Strange Confession in Staffordshire', *The Times*, 13 January 1882, p. 10.For more background on the emergence of the term, and the types of behaviour to which it referred, see Sarah Chaney, 'Self-Control, Selfishness and Mutilation: How "Medical" is Self-Injury Anyway?', *Medical History*, 55 (2011), 375–83; Sarah Chaney, '"A hideous torture on himself": Madness and Self-Mutilation in Victorian Literature', *Journal of Medical Humanities*, 32 (2011), 279–89.

13. T. N. Brushfield, 'On Medical Certificates of Insanity', *The Lancet*, 115 (1880), 711–13; Henry Rayner, 'Melancholia and Hypochondriasis', in *A System of Medicine*, ed. by T. Clifford Albutt (London: Macmillan, 1899), pp. 361–81; Maury Deas, pp. 102–13.

14. 'Asylum Reports for 1871', *Journal of Mental Science*, 18 (1872), 262–76 (p. 274).

15. For this distinction between suicide and self-homicide, see Rayner, p. 369.

16. J. A. Mangan and James Walvin, *Manliness and Morality: Middle-Class Masculinity in Britain and America, 1800–1940* (Manchester: Manchester University Press, 1987).

17. Jeremy Bentham, *An Introduction to the Principles of Morals and Legislation*, ed. by Benjamin Giles King (London: Pickering and Wilson, 1823), p. 1; Alexander Bain, *The Emotions and the Will* (London: Parker, 1859), esp. pp. 31–35 and pp. 336–50.

18.

Lorraine J. Daston, 'The Theory of Will versus the Science of Mind', in *The Problematic Science: Psychology in Nineteenth-Century Thought*, ed. by William Ray Woodward and Mitchell G. Ash (New York: Praeger, 1982), pp. 88–115; Robert M. Young, *Mind, Brain and Adaptation in the Nineteenth Century* (Oxford: Clarendon Press, 1970), pp. 101–33.

19. R. von Krafft-Ebing, *Text-Book of Insanity: Based on Clinical Observations for Practitioners and Students of Medicine* (Philadelphia: Davis, 1904), p. 120.

20. W. Griesinger, 'German Psychiatrie; An Introductory Lecture, Read at the Opening of the Psychiatric Clinique, in Zürich', *Journal of Mental Science*, 9 (1864), 531–47 (p. 533).

21. For a history of the latter idea see Roger Smith, *Inhibition: History and Meaning in the Sciences of Mind and Brain* (London: Free Association Books, 1992).

22. W. C. McIntosh, 'On some of the Varieties of Morbid Impulse and Perverted Instinct', *Journal of Mental Science*, 11 (1866), 512–33 (p. 528).

23. James C. Howden, 'Notes of a Case — Mania followed by Hyperaesthesia and Osteomalacia. Singular Family Tendency to Excessive Constipation and Self-Mutilation', *Journal of Mental Science*, 28 (1882), 49–53; Sydney Coupland, 'Hysterical Anaesthesia', *The Lancet*, 110 (1877), 644–45.

24. Michael J. Clark, '"The data of alienism": Evolutionary Neurology, Physiological Psychology, and the Reconstruction of British Psychiatric Theory, c.1850–c.1900' (unpublished doctoral thesis, University of Oxford, 1983).

25.George Savage, 'The Influence of Surroundings on the Production of Insanity', *Journal of Mental Science*, 37 (1891), 529–35 (p. 529); George Savage, 'Henry Maudsley', *Journal of Mental Science*, 64 (1918), 117–29 (p. 118).

26.Theo Hyslop, *Mental Physiology: Especially in its Relations to Mental Disorders* (London: Churchill, 1895).

27. A similar point is made by Ian Hacking, *Mad Travelers: Reflections on the Reality of Transient Mental Illnesses* (Charlottesville: University Press of Virginia, 1998).

28. Kent County Archives (KCA), *West Malling Place Case Histories (Visitors)*, 1877–1893, p. 200 (Ch84 / Mc3).

29.George Savage, 'Presidential Address, Delivered at the Annual Meeting of the Medico-Psychological Association', *Journal of Mental Science*, 32 (1886), 313–31.

30. Bethlem Royal Hospital Archives (BRHA), *Female Patient Casebook 1889*, p. 76 (CB/137).

31. BRHA, *Male Patient Casebook 1897*, p. 21 (CB/156).

32. BRHA, *Female Patient Casebook 1860*, p. 39 (CB/77).

33. See the continuing recommendation of bloodletting by some physicians into the twentieth century in G. B. Risse, 'Renaissance of Bloodletting — Chapter in Modern Therapeutics', *Journal of the History of Medicine and Allied Sciences*, 34 (1979), 3–22.

34. BRHA, *Male Patient Casebook 1880*, p. 70 (CB/116); BRHA, *Male Patient Casebook 1900*, p. 50 (CB/163).

35. BRHA, *Male Patient Casebook 1889,* p. 18 (CB/136).

36. BRHA, *Female Patient Casebook 1892*, p. 113 (CB/144).

37. For background on 'altruism', see Thomas Dixon, *The Invention of Altruism: Making Moral Meanings in Victorian Britain* (Oxford: Oxford University Press, 2008); Stefan Collini, *Public Moralists: Political Thought and Intellectual Life in Britain 1850–1930* (Oxford: Clarendon Press, 1991).

38. Vern L. Bullough, *Science in the Bedroom: A History of Sex Research* (New York: Basic Books, 1994); Harry Oosterhuis, *Stepchildren of Nature: Krafft-Ebing, Psychiatry, and the Making of Sexual Indentity* (Chicago: University of Chicago Press, 2000);

39. Michel Foucault, *The History of Sexuality: The Will to Knowledge* (London: Penguin, 1998).

Communications or questions concerning admission to LIU Pharmacy should be submitted to the following:

Office of Admissions
LIU Brooklyn
1 University Plaza
Brooklyn, NY 11201-5372
Phone: 718-488-1011 or 1-800-LIU-PLAN
Fax: 718-797-2399
E-mail: admissions@brooklyn.liu.edu
Website: www.liu.edu/brooklyn/admissions
OFFICE HOURS
Monday & Thursday, 9:00 a.m. – 5:00 p.m.
Tuesday & Wednesday, 9:00 a.m. – 6:00 p.m.
Friday (during summer), 9:00 a.m. – 4:00 p.m.
Please contact the LIU Brooklyn Office of Admissions regarding receipt of your application.

PROFESSIONAL PROGRAM (PHARM.D.)
Office of Student and Professional Affairs
LIU Pharmacy
75 DeKalb Avenue, L130
Brooklyn, NY 11201-5372